LIBRARY
BOSTON UNIVERSITY
SCHOOL OF MEDICINE

JUL 21 1950

VOLUME 5 • JULY 1950 • NUMBER 7

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

Library of Boston University
School of Medicine
80 E. Concord St.,
Boston, Mass.

LIBRARY
BOSTON UNIVERSITY
SCHOOL OF MEDICINE

Official Publication of

for high potency chorionic gonadotropin

specify "A.P.L."®

dependable, biologically standardized chorionic gonadotropin derived from human pregnancy urine.

for sustained relief in chronic cystic mastitis

specify "A.P.L."®

which has also long proved helpful in the treatment of threatened abortion, functional uterine bleeding, cryptorchidism, hypogenitalism, Fröhlich's syndrome, and impotence.

specify "A.P.L."®

for chorionic gonadotropin

in dry form and sterile solution

Dry Form

(to facilitate administration of massive dosages)
No. 972—Each package provides:

1. One "Secule"* containing 20,000 I.U.
2. One 10 cc. vial sterile diluent (containing 0.5% phenol). May be reconstituted to a volume of 5 or 10 cc., thus providing concentrations of 4,000 or 2,000 I.U. per cc. as required.

Sterile Solution

No. 500—500 I.U. per cc.—10 cc. vials
No. 999—1,000 I.U. per cc.—10 cc. vials

*"Secule®"—Ayerst name to designate a special vial containing an injectable preparation in dry form.

specify

Ayerst®

Ayerst, McKenna & Harrison Limited

22 East 40th Street, New York 16, N. Y.

5012

IN THE MANAGEMENT OF

Diarrhea of Infancy

"The ideal initial form of nourishment is apple powder . . . Its value lies in the fact that when administered in full dosage it enables the infant's digestive apparatus to tolerate and to utilize a high calory, high protein diet, provided the sugar content is kept low."[1]

appella®

APPLE POWDER

Prompt Control of Diarrhea · No Constipation · No Starvation

Average dose 4 level teaspoonfuls three times daily. Make thick paste first, then gradually dilute to consistency of apple sauce. Feed from spoon or dilute further and administer through enlarged nipple opening. Supplied in 7 oz. and 18 oz. jars.

Winthrop-Stearns INC.
NEW YORK 13, N. Y. WINDSOR, ONT.

1. O'Keefe, E. S.: *Am. Jour. Dis. Child.*, 76:616, Dec., 1948.

appetite must be controlled

"The greatest problem in preventive medicine in the United States today is obesity."[1] And today it is well-known that *"The only way to counteract obesity . . . is by a restriction of food intake."*[2]

'Dexedrine' Sulfate controls appetite, making it easy for the patient to avoid overeating and thus to lose weight safely without the use (and risk) of such potentially dangerous drugs as thyroid. In weight reduction 'Dexedrine' *"is the drug of choice because of its effectiveness and the low incidence of undesirable side effects."*[1]
Smith, Kline & French Laboratories • Philadelphia

Dexedrine* Sulfate tablets • elixir

A most effective drug for control of appetite in weight reduction

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.

2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

Official Monthly Publication of the American Medical Women's Association, Inc.

VOLUME 5 | JULY 1950 | NUMBER 7

INTERNATIONAL NUMBER

ORIGINAL ARTICLES

Agglutination with Sensitized Sheep Cells in Rheumatoid Arthritis, *Nanna Svartz, M.D.*, Stockholm, Sweden..261

Female Infertility and Sterility, Endocrine Factors, *Rita S. Finkler, M.D.*, and *Sylvia F. Becker, M.D.*, Newark, N. J., U.S.A. 263

RECENT ADVANCES IN MEDICINE

Progress in Psychiatry, *Zelda Teplitz, M.D.*, Chicago, Ill., U.S.A. 269

SEMINARS IN THERAPY

Treatment of Peptic Ulcer, A Symposium by Members of the Faculty of the Woman's Medical College of Pennsylvania, Philadelphia, Pa., U.S.A. 275

EDITORIAL

World Health Organization, *Ada Chree Reid, M.D.*, New York, N. Y., U.S.A. 278

Third World Health Assembly 279

SPECIAL ARTICLES

WHO around the World 280

The International Tuberculosis Campaign, *Esther Ammundsen, M.D.*, Copenhagen, Denmark....284

International Cancer Meetings, *Perihan Cambel, M.D.*, Ankara, Turkey 285

Medical Women and Group Practice as Seen by a Canadian, *Agnes K. Moffat, M.D.*, Ontario, Canada....287

Medical Women in Finland, *Anni Seppanen, M.D.*, Helsinki, Finland 291

The Rachel Forster Hospital for Women and Children, *Mary C. Puckey, M.D.*, Sydney, Australia....294

REGULAR FEATURES

News of Women in Medicine 297

Book Notices 303

ASSOCIATION NEWS AND ANNOUNCEMENTS

Medical Women's International Association 300

American Medical Women's Association

President's Message 301

New Members 301

Editorial Board ....Adv. 4

International Correspondents ....Adv. 6

Directory of Officers ....Adv. 8

Index of Advertisers ....Adv. 16

Classified Advertisements ....Adv. 15

Neither the Editors nor the Publisher of the Journal of the American Medical Women's Association are responsible for any statements made or opinions expressed by any of its contributors.

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is published monthly by the American Medical Women's Association, Inc., at 136 4th Ave., Nashville 3, Tenn. Entered as second class matter at the Post Office at Nashville, Tennessee, under the Act of August 24, 1912. Acceptance for mailing at special rates of postage provided for in Section 1102, Act of October 8, 1917, and authorized July 15, 1918.

Copyright 1950 by the American Medical Women's Association, Inc.

Subscription, $5.00 per year; 50c single copy.

EDITORIAL AND CIRCULATION OFFICE, Journal of the American Medical Women's Association, 3B, 118 Riverside Drive, New York 24, N. Y. Telephone, TRafalgar 3-3656.

ADVERTISING OFFICE: Suite 205, 420 Lexington Avenue, New York 17, N. Y. Gladys Huss. Telephone, LExington 2-9231.

Editorial Board

JANET K. AITKEN, C.B.E., M.D., F.R.C.P.....*London, England*
INES L. C. DE ALLENDE, M.D.....*Cordoba, Argentina*
LEONA BAUMGARTNER, M.D.....*New York, N. Y.*
CARROLL LAFLEUR BIRCH, M.D.....*Chicago, Ill.*
NINA FAY CALHOUN, M.D.....*Dallas, Texas*
MARY M. CRAWFORD, M.D.....*New York, N. Y.*
BEULAH CUSHMAN, M.D.....*Chicago, Ill.*
MARIA PAUMGARTTEN DEANE, M.D.....*Belem, Pará, Brazil*
GLADYS H. DICK, M.D.....*Chicago, Ill.*
DELLA GAY DRIPS, M.D.....*Rochester, Minn.*
FAITH S. FETTERMAN, M.D.....*Philadelphia, Pa.*
RITA S. FINKLER, M.D.....*Newark, N. J.*
GRACE A. GOLDSMITH, M.D.....*New Orleans, La.*
EDNA M. GUEST, O.B.E., M.D.....*Toronto, Canada*
ANNA HUBERT, M.D.....*New York, N. Y.*
HELEN JOHNSTON, M.D.....*Des Moines, Iowa*
ZOE ALLISON JOHNSTON, M.D.....*Pittsburgh, Pa.*
MARGARET H. JONES, M.D.....*Los Angeles, Calif.*
JOSEPHINE H. KENYON, M.D.....*New York, N. Y.*
ELIZABETH KITTREDGE, M.D.....*Washington, D. C.*
LEILA C. KNOX, M.D.....*New York, N. Y.*
IRENE A. KOENEKE, M.D. .....*Halstead, Kansas*
ESTHER P. LOVEJOY, M.D.....*New York, N. Y.*
CATHARINE MACFARLANE, M.D.....*Philadelphia, Pa.*
HELEN MACMURCHY, C.B.E., M.D.....*Toronto, Canada*
MINNIE LEE MAFFETT, M.D.....*Dallas, Texas*
DAME A. LOUISE MCILROY, O.B.E., M.D.....*London, England*
HARRIET C. MCINTOSH, M.D.....*New York, N. Y.*
ANITA M. MUHL, M.D.....*San Diego, Calif.*
DOROTHY KLENKE NASH, M.D.....*Pittsburgh, Pa.*
LOUISE PEARCE, M.D.....*Princeton, N. J.*
GILDA PERAZA, M.D.....*Havana, Cuba*
ELLEN C. POTTER, M.D.....*Trenton, N. J.*
BARBARA B. STIMSON, M.D.....*New York, N. Y.*
CARMEN C. THOMAS, M.D., D.Sc. (Med.).....*Philadelphia, Pa.*
MARGARET C. TOD, F.R.C.S.E., F.F.R.....*Manchester, England*
EDNA H. TOMPKINS, M.D.....*New Haven, Conn.*
RUTH WELLS, M.D.....*Pasadena, Calif.*
PRISCILLA WHITE, M.D.....*Boston, Mass.*
KATE SAVAGE ZERFOSS, M.D.....*Nashville, Tenn.*

Specialists

Anesthesia .....LOIS L. WELLS, M.D., *Oklahoma City, Okla.*
Gynecology .....ELOISE PARSONS, M.D., *Chicago, Ill.*
Medicine .....MARION N. GIBBONS, M.D., *Shaker Heights, Ohio*
Obstetrics.....ISABEL KNOWLTON, M.D., *New York, N. Y.*
Orthopedic Surgery .....RUTH JACKSON, M.D., *Dallas, Texas*
Pathology .....SOPHIE SPITZ, M.D., *New York, N. Y.*
Pediatrics .....MAY BORQUIST GUY, M.D., *Seattle, Wash.*
Psychiatry .....JOAN FLEMING, M.D., *Chicago, Ill.*
Public Health ....HELEN M. WALLACE, M.D., *New York, N. Y.*
Radiology .....HARRIET C. MCINTOSH, M.D., *New York, N. Y.*
Surgery ....MARGARET STANLEY-BROWN, M.D., *New York, N. Y.*

EDITOR
ADA CHREE REID, M.D.
New York, N. Y.

ASSOCIATE EDITOR
DOROTHY W. ATKINSON, M.D.
San Francisco, Calif.

EDITORIAL CONSULTANT
ELISE S. L'ESPERANCE, M.D.
New York, N. Y.

DEPARTMENTAL EDITORS

Recent Advances in Medicine
PATRICIA TUDBURY, M.D.
San Francisco, Calif.

Reports of Proceedings
MARGARET S. TENBRINCK, M.D.
New York, N. Y.

Seminars on Therapy
FRIEDA BAUMANN, M.D.
Philadelphia, Pa.

News of Women in Medicine
MARCELLE BERNARD, M.D.
New York, N. Y.

Medical School and Student News
EVA F. DODGE, M.D.
Little Rock, Ark.

PUBLICATION COMMITTEE
AMEY CHAPPELL, M.D.
Atlanta, Ga.

BUSINESS and EDITORIAL OFFICE, 118 Riverside Drive, New York 24, N. Y.

AN EFFECTIVE PRECAUTION IN

Patients Subject to

Angina Pectoris

Erythrol Tetranitrate Merck, taken orally shortly before unusual exertion, emotional upset, exposure to cold, or a heavy meal, may often prevent precordial pain and discomfort. Because of the mild, gradual vasodilatation of several hours' duration produced by this drug, administration at bedtime may be of value in preventing nocturnal attacks of angina.

Literature will be mailed to you on request.

MERCK & CO., Inc.
Manufacturing Chemists
RAHWAY, N. J.

MERCK

Erythrol Tetranitrate Merck

(Erythrityl Tetranitrate U.S.P.)

COUNCIL ACCEPTED

International Correspondents

Africa, South	Dr. Marie Van Castricum	*Johannesburg*
Argentina	Dra. Ines L. C. de Allende	*Cordoba*
Australia	Dr. Ida Saunders	*Sydney*
Austria	Dr. Lore Antoine	*Vienna*
Belgium	Dr. Michotte-Ronse	*Bruxelles*
Brazil	Dra. Maria Paumgartten Deane	*Pará*
Burma	Dr. Yin May	*Rangoon*
Canada	Dr. Anna Wilson	*Ottawa*
Chile	Dra. Maria Alvarez Arnold	*Valparaiso*
China, East	Dr. Tsae N. Kwong	*Shanghai*
China, North	Dr. Marion Yang	*Peking*
China, South	Dr. H. H. Huang	*Canton*
China, West	Dr. Gladys Cunningham	*Chengtu*
Cuba	Dra. Gilda Peraza	*Habana*
Czechoslovakia	Dr. Vlasta Kalalova di Lotti	*Praha*
Denmark	Dr. Agnete Heise	*Copenhagen*
England	Dr. Georgiana Bonser	*Leeds*
England	Dr. Dorothy Anderton-Sharpe	*London*
Finland	Dr. Anni Seppanen	*Helsinki*
France	Dr. Gauthier-Villars	*Paris*
Germany	Dr. Gabriele Strecker	*Frankfurt*
Greece	Dr. Dora Papara	*Athens*
Guatemala	Dra. Maria Isabel Escobar	*Guatemala*
Haiti	Dr. Yvonne G. Silvain	*Port au Prince*
Holland	Dr. Henrietta A. Lohr	*Amsterdam*
Hungary	Dr. Vilma Sebesta	*Budapest*
India, North	Dr. Josephine Asirvatham	*Lucknow*
India, South	Dr. Hilda Lazarus	*South Vellore*
Indonesia	Dr. Cornelia de Ranitz	*Batavia*
Iran	Dr. Miriam Fahimi	*Teheran*
Israel	Dr. Helen Kagan	*Jerusalem*
Italy	Dr. Mara Selvini	*Milan*
Korea	Dr. Rhoda Kim Pak	*Chunchan*
Mexico	Dra. Alicia Gallaga Romero	*Anahuac*
Mongolia	Mother Mary Franciscus, M.D.	*Ninghia*
Morocco	Dr. Lucia Servadio Bedarida	*Tangier*
New Zealand	Dr. S. Sinclair	*Dunedin*
North Ireland	Dr. F. Mary Erskine	*Belfast*
Norway	Dr. Herdis Gundersen	*Olso*
Panama	Dra. Lidia G. Soganderes	*Santa Tomas*
Pakistan	Dr. Z. Nasiruddin	*West Punjab*
Peru	Dra. Imelda Lindo de Soriano	*Lima*
Portugal	Dr. Nair de Azevedo	*Lisbon*
Scotland	Dr. Mary Esslemont	*Aberdeen*
Siam	Dr. Pierra Vejjabul	*Bangkok*
Spain	Dr. Alicia Fernandez Calvet	*Galicia*
Sweden	Dr. Andrea Andreen	*Stockholm*
Switzerland	Dr. Ilse Schnabel	*Zurich*
Turkey	Dr. Perihan Cambel	*Ankara*

FACT: Johnson's Baby Lotion with hexachlorophene 1% has been demonstrated to be a specific preventive and therapeutic agent for five common skin afflictions of infancy: impetigo contagiosa, miliaria rubra, cradle cap, excoriated buttocks, and diaper rash.

PROOF: New Johnson's Baby Lotion was subjected to clinical investigations in 8 leading hospitals for a period of more than 10,000 baby days. It reduced the incidence of skin irritations *of all types* to an average of less than 2%.

NEW-FORMULA

JOHNSON'S BABY LOTION

Johnson & Johnson

FREE!
12 distribution samples of new Johnson's Baby Lotion.
Mail this coupon.

Johnson & Johnson
Baby Products Division
Dept. W5, New Brunswick, N. J.

Please send me, free of charge, 12 distribution samples of Johnson's Baby Lotion.

Name_____

Street_____

City_____ State_____

Offer limited to medical profession in U.S.A.

AMERICAN MEDICAL WOMEN'S ASSOCIATION
1950-1951

OFFICERS

President
ELIZABETH S. WAUGH, M.D.
348 Green Lane, Philadelphia 28, Pa.

President-Elect
AMEY CHAPPELL, M.D.
795 Peachtree St., N.E., Atlanta, Ga.

Retiring President
DOROTHY W. ATKINSON, M.D.
490 Post St., San Francisco 2, Calif.

First Vice-President
EVANGELINE E. STENHOUSE, M.D.
55 East Washington St., Chicago 2, Ill.

Second Vice-President
JUDITH AHLEM, M.D.
954 South L St., Livermore, Calif.

Corresponding Secretary
MILDRED PFEIFFER, M.D.
Philadelphia, Pa.

Recording Secretary
MARGARET EDWARDS, M.D.
Philadelphia, Pa.

Treasurer
MARY RIGGS NOBLE, M.D.
Bowmansdale, Pa.

Editor
ADA CHREE REID, M.D.
118 Riverside Drive, New York 24, N. Y.

National Corresponding Secretary to the Medical Women's International Association
MARGARET M. WURTS, M.D.
27 East Wellesley Rd., Montclair, N. J.

REGIONAL DIRECTORS

New England
ELIZABETH WELLS, M.D. (1951-'53)
30 West Beacon St., Hartford 5, Conn.

North Atlantic
ADELAIDE ROMAINE, M.D. (1948-'52)
35 West 9th St., New York 11, N. Y.

Middle Atlantic
H. GLADYS KAIN, M.D. (1948-'51)
1801 Eye St., N.W., Washington 6, D. C.

South Atlantic
JEAN JONES PURDUE, M.D. (1949-'52)
541 Lincoln Rd., Miami Beach 41, Fla.

North Central
KATHARINE W. WRIGHT, M.D. (1951-'53)
811 Lincoln St., Evanston, Ill.

Southeast Central
HELEN M. DEANE, M.D. (1948-'51)
1126 Kirkland Ave., Nashville 6, Tenn.

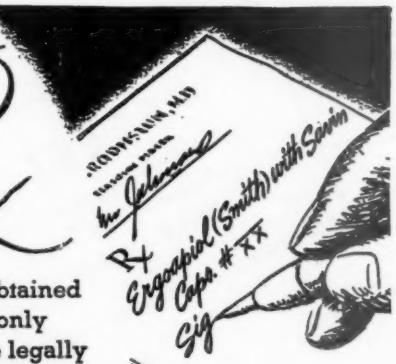
Northwest Central
NELLIE M. BARSNESS, M.D. (1949-'52)
540 Lowry Medical Arts Bldg., St. Paul 2, Minn.

Southwest Central
CORA DYCK, M.D. (1949-'52)
Moundridge, Kansas

Northwest
MIRIAM LUTEN, M.D. (1951-'53)
105 N.E. 61st St., Portland 16, Ore.

Southwest
ANTOINETTE LE MARQUIS, M.D. (1951-'53)
San Diego, Calif.

Only on your Rx



When prescribing Ergoapiol (Smith) with Savin for your gynecologic patients, you have the assurance that it can be obtained only on a written prescription, since this is the only manner in which this ethical preparation can be legally dispensed by the pharmacist. The dispensing of this **uterine tonic,** time-tested ERGOAPIOL (Smith) WITH SAVIN—only on your prescription—serves the best interests of physician and patient.

INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.

GENERAL DOSAGE: One to two capsules, three to four times daily—as indications warrant.

In ethical packages of 20 capsules each, bearing no directions.

Literature Available to Physicians Only.

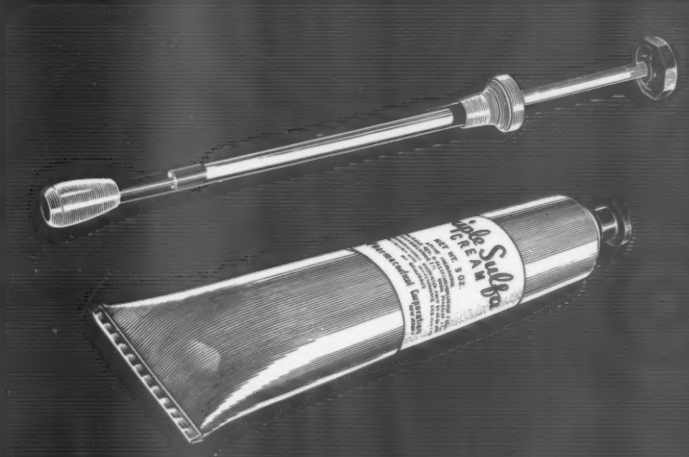
Ethical protective mark, M.H.S., visible only when capsule is cut in half at seam.

ERGOAPIOL (SMITH) WITH SAVIN

MARTIN H. SMITH COMPANY
150 LAFAYETTE STREET
NEW YORK 13, N.Y.

Triple Sulfa Cream

TRADE MARK



combats a wide variety of vaginal pathogens

Bacterial and nonspecific vaginitis are usually mixed infections. In a recent series, an average of 7 organisms per patient was found.[1] TRIPLE SULFA CREAM is highly effective against vaginal infections because each of its three sulfonamides* has optimal antibacterial activity at the different degrees of acidity, corresponding to those at which common vaginal pathogens flourish.

TRIPLE SULFA CREAM

1. Eliminates malodorous discharge quickly
2. Well tolerated—"no sensitivity was observed"[2]
3. Easily administered with an Ortho Applicator

Following cervical cautery or conization and vaginal plastic operations, TRIPLE SULFA CREAM reduces healing time by as much as 50%.[2] "The absence of the usual postcautery discharge and bleeding was very striking."[1]

TRIPLE SULFA CREAM is available in 3 ounce tubes with or without the Ortho Vaginal Applicator. On original prescriptions specify "TRIPLE SULFA CREAM with applicator."

1. Blinick, G.; Steinberg, P., and Merendino, J. V.: Am. J. Obst. & Gynec. 58:176, 1949. 2. Marbach, A. H.: Am. J. Obst. & Gynec. 55:511, 1948.

*Sulfathiazole, N'acetylsulfanilamide, N'benzoylsulfanilamide

ortho pharmaceutical corporation, raritan, n. j.

GYNECIC PHARMACEUTICALS

Fashioned for femininity
Designed for discreetness

Ortho Kit

Complete for every contraceptive need

Ortho Gynol® Vaginal Jelly—Phenylacetic acid 0.75%, boric acid 3.0% and sodium lauryl sulphate 0.025%

Ortho® Creme Phenylacetic acid 0.75%, boric acid 2.0%, Sodium lauryl sulphate 0.28%

one source for everything in X-ray

apparatus
Everything in fine x-ray equipment . . . from a small portable unit to massive deep therapy apparatus (including the Allis-Chalmers 24 million-volt Betatron).
supplies
Everything in fine x-ray supplies and accessories . . . from a few films to comprehensive large-scale installations . . . even a thermometer for blind dark-room technicians, should you want one.
layout
Everything in x-ray lay-out planning . . . and an expert engineering staff to help you with anything from a single room to whole floors.
service
Everything in x-ray service and maintenance . . . through a trained corps of servicemen and engi-neers, and at strategic locations.
PICKER X-RAY CORP.
SERVICE ENGINEERING
Picker x-ray

There's a Picker Sales Office and Service Depot near you, staffed by capable men eager to serve you well. Picker X-Ray Corp., 300 Fourth Avenue, N. Y. 10.

SIMPLE TEST PROVES *INSTANTLY* PHILIP MORRIS ARE LESS IRRITATING

*Now you can confirm for yourself, Doctor, the results of the published studies**

HERE IS ALL YOU DO:

1 ..light up a PHILIP MORRIS
Take a puff—DON'T INHALE. Just s-l-o-w-l-y let the smoke come through your nose. AND NOW

2 ..light up your present brand
DON'T INHALE. Just take a puff and s-l-o-w-l-y let the smoke come through your nose. Notice that bite, that sting? Quite a difference from PHILIP MORRIS!

With proof so conclusive... with your own *personal experience* added to the published studies*... would it not be good practice to suggest PHILIP MORRIS to your patients who smoke?

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

when pregnancy is contraindicated . . .

A COMPARATIVE STUDY

THE EFFICACY OF THE SUPPOSITORY FOR CONCEPTION CONTROL

"". . . surely mass studies on the diaphragm have not shown greater efficacy than is reported in this paper by simpler procedures."*

Lorophyn® Suppositories (N.N.R.) contain phenylmercuric acetate 0.05% and glyceryl laurate 10% in a water-dispersible, self-emulsifying, synthetic wax base. Hermetically sealed in foil, they will not leak in hot weather.

The Baltimore Study.

Studies of the efficacy of Lorophyn Suppositories in a Baltimore clinic revealed that this method produced a total rate of *16.2* pregnancies per 100 woman-years of exposure to the opportunity of becoming pregnant. This rate was compared to some reported in the literature with diaphragm and jelly: 12, 15, 18 and 33.

The South Carolina Study.

In State post-natal and syphilis clinics, the effectiveness of the simple Lorophyn Suppository technic was found to be comparable to the Baltimore results.

*Eastman, N. J. & Seibels, R. E.: *The Efficacy of the Suppository and of Jelly Alone as Contraceptive Agents,* J. A. M. A. **139**:16 (Jan. 1) 1949. **Reprint on request.**

EATON LABORATORIES, INC., NORWICH, N. Y.

When a jelly is preferred—**LOROPHYN JELLY (N.N.R.)** also contains the powerful spermicide: phenylmercuric acetate 0.05%, and polyethylene glycol of mono-iso-octyl phenyl ether 0.3%, methyl p-hydroxy benzoate 0.05% and sodium borate 3% in a special jelly base.

when

there's

no escape

from forbidden

foods

● Weakened by hunger and pursued by relentless temptations, her already meager powers of resistance are nearly exhausted. At this point, the judicious use of DESOXYN Hydrochloride can avert complete surrender.

With DESOXYN, small doses are sufficient to produce the desired cerebral effect—anorexia, elevation of mood and desire for activity—without producing undesirable side-effects. One 2.5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient. Some patients may require a third tablet about 3:30 in the afternoon. Medication after 4 p.m. may cause insomnia in some persons. With small oral doses, no pressor effect has been observed.

Smaller dosage is possible because, milligram for milligram, DESOXYN is more potent than other sympathomimetic amines. DESOXYN also has the advantages of faster action, longer effect. Why not give it a trial? Unless contraindicated, small doses are harmless—can add many weeks to the life expectancy of the reducing diet. Abbott

See that the Rx reads

DESOXYN®

hydrochloride

(Methamphetamine Hydrochloride, Abbott)

Tablets
2.5 and 5 mg.

Elixir
20 mg. per fluidounce
(2.5 mg. per fluidrachm)

Ampoules
20 mg. per cc.

"valuable therapeutic agent in dermatologic practice"[1]

4 excerpts from the literature on Vioform

Overton "The effect of 3% Vioform in a water-miscible base or in petroleum jelly has been assessed under carefully controlled conditions on a variety of dermatoses in 176 patients. It proved a useful local application in the treatment of the following conditions: coccogenic sycosis barbae, seborrhoeic dermatitis, otitis externa, acute vesiculo-papular eczema. The incidence of cases of intolerance was low."[2]

Sulzberger & Baer "Both long clinical experience and the present studies indicate that Vioform (5-chloro-7-iodo-8-hydroxyquinoline) is a valuable remedy in topical therapy. . . . Since submitting this report we have confirmed our observations in hundreds of additional cases. The results have strengthened our conviction that Vioform preparations, while not panaceas, are among the most valuable local therapeutic agents with very low irritancy and a low index or potential of sensitization."[3]

Martin-Scott ". . . in at least 37 cases in which penicillin had failed Vioform produced the desired result. . . . It is concluded that 3% vioform is a valuable addition to the medicants at present used in this country for pyococcal dermatoses."[1]

Perlman "Its results in the treatment of infantile eczema, as well as in the eczemas of older children, have been found good . . . in fact, on occasions Vioform has been proved to be the topical answer to eczema when orthodox treatment with the tars failed."[4]

1. Martin-Scott, I.: Brit. Med. J., May 14, 1949
2. Overton, J.: Brit. Med. J., May 14, 1949
3. Sulzberger & Baer: Arch. Derm. & Syph., 58: Aug. 1948
4. Perlman, H. H.: J. of Pediat., July 1948

Vioform

cream — 3% in a special water-washable (flesh color vanishing cream) base—50 Gm. jars and 1 pound jars.

ointment — 3% in a petrolatum base (tends to stain, should be covered in use)—50 Gm. jars and 1 pound jars.

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

VIOFORM (brand of iodochlorhydroxyquinoline)—Trade Mark Reg. U.S. Pat. Off. 2/1570M

"Sweet is pleasure after pain" — as Dryden put it — might well be a description of the welcome relief from discomfort which is bestowed upon injured skin or the mucosa of the genito-urinary and rectal areas by 'Surfacaine' (Cyclomethycaine, Lilly). A single topical application usually produces anesthesia lasting up to eight hours. Its low toxicity, however, permits more frequent use in extremely severe conditions. Available in a wide variety of effective forms:

OINTMENT • CREAM • LOTION • SUPPOSITORIES • JELLY

SURFACAINE

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

Complete literature on 'Surfacaine' is available from your Lilly medical service representative or will be forwarded upon request.

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 5 JULY 1950 NUMBER 7

Agglutination with Sensitized Sheep Cells in Rheumatoid Arthritis

Nanna Svartz, M.D.

In 1922, Meyer showed that in certain cases human blood gives a strong agglutination of sensitized sheep cells, i.e., red sheep cells treated with serum from a rabbit that has been immunized with such cells. However, he makes no mention of the occurrence of such agglutination in cases of arthritis. Waaler studied a similar reaction in rheumatoid arthritis, but he obtained a positive result in only 35 percent of the sera examined, and he therefore considered the test to have no practical significance.

Rose and his asociates at Columbia University, while engaged on investigations into Rickettsia, found that rheumatoid arthritis frequently yielded a strikingly strong agglutination of sheep cells and that this reaction usually showed a higher titre if sensitized sheep cells were used. According to various subsquent investigators, this reaction proved to be positive in 35 to 40 percent of cases of rheumatoid arthritis.

In collaboration with K. Schlossmann, I have worked out a new modification of sheep-cell agglutination which has given a positive result in about 90 percent of such cases. The most important point about these tests is this: In human blood there invariably occur agglutinins against untreated sheep cells. In the form of sheep-cell agglutination proposed by us the reaction proper on the blood serum is not brought about until after the agglutinins against normal erythrocytes have been eliminated from it. This occurs through the absorption of serum with normal sheep cells. By further modifying the method we have succeeded in producing a sensitive test.

The results achieved so far are shown in the table.

It should be mentioned that in some cases in which the diagnosis "rheumatoid arthritis" was considered, prior to the test, to leave no room for doubt, but in which the agglutination reaction with sensitized sheep cells turned out negative, subsequent examination indicated that another form of arthritis was present.

The only disease, apart from rheumatoid arthritis, in which the test carried out by us frequently shows a strongly positive reaction would appear to be lupus erythematosus disseminatus. Rheumatic fever has not yielded a positive reaction, possibly because agglutinins have not yet had time to form.

As the table shows, *joint exudates* in cases of rheumatoid arthritis give a reaction as strongly positive as that of serum.

Further, we have carried out a series of investigations in order to ascertain the nature of the

Dr. Svartz is Director of the King Gustav V. Research Institute, and Professor of Medicine, Karolinska Institute, Stockholm, Sweden.

RHEUMATOID ARTHRITIS	No. of patients	Strong agglutination (positive react.)	Weak agglutination	No agglutination (negative react.)
Sera	105	94	7	4
Joint fluid	4	4		
OTHER DISEASES AND HEALTHY CASES				
Sera	137	8	42	87
Joint fluid (traumatic)	2		2	

agglutination reaction described here. We have found, inter alia, that if blood serum or joint exudate from rheumatoid arthritis is injected intravenously into a rabbit, there arises in the rabbit an agglutinating factor of the same type as that in patients suffering from rheumatoid arthritis. It is in our opinion a highly interesting fact that a similar agglutinating substance is formed upon immunizing a rabbit with certain types of cocci, especially enterococci and pneumococci type 42.

It is also worthy of note that upon giving an injection of blood serum or joint exudate from patients suffering with rheumatoid arthritis we are able to demonstrate that, besides the agglutinating factor, there is also formed in the rabbit, as a rule, a substance that is capable of checking the reaction.

The ability of a large number of other substances to check the sheep-cell agglutination has been tested subsequently. The kidney of a guinea pig checks the agglutination with normal sheep cells, whereas it has no effect on the agglutination with sensitized sheep cells. Nor does an addition *in vitro* of ACTH check the later reaction. A negative result is likewise obtained with desoxicorticosteronacetate.

Schlossmann and I have produced a raw extract from the suprarenal capsules of guinea pigs and other animals, and we have found that, unlike kidney extract, this extract checks the agglutination reaction.

Our observations on the agglutination of sensitized sheep cells in patients treated with ACTH are considered to be of both theoretical and practical significance. It is a known fact that bacterial agglutinins and also streptolysins and staphylolysins in the blood of patients treated with ACTH or cortisone are often reduced. This is not the case with the agglutinating factor against sensitized sheep cells in cases of rheumatoid arthritis. Thus it is not influenced by treatment with ACTH.

We are continuing our investigations into the agglutination reaction with sensitized sheep cells. This reaction would appear to be the first observed serologic reaction that yields a positive result in the majority of cases of rheumatoid arthritis. In fact, it seems to be practically a specific quality of rheumatoid arthritis.

REFERENCES

Meyer, K., Zeitschr. Immunitatsf. Orig. **34:** 229, 1922.

Waaler, P., Acta path. et microbiol. Scand. **17:** 172, 1940.

Rose, H. M., Regan, C., Pearce, E., and Lipman, M. O., Proc. Soc. Exper. Biol & Med. **68:** 1, 1948.

Svartz, N., and Schlossmann, K., Nordisk Medicin **42:** 1930, 1942.

Svartz, N., Proceedings, Congress on Rheumatic Diseases, New York, 1949 (in print).

Female Infertility and Sterility

ENDOCRINE FACTORS

Rita S. Finkler, M.D. and Sylvia F. Becker, M.D.

AMONG THE NUMEROUS FACTORS which contribute to sterility and infertility in the female, endocrine disturbances play an important role. In a series of 415 women treated for sterility over a period of 10 years we were able to classify 160, or 38.5 percent as having functional or endocrine sterility.

Occasionally patients presenting signs and symptoms of endocrine disturbances may have co-existing pelvic pathologic conditions which may account for their infertility. Such cases are not to be considered as purely functional. In arriving at a diagnosis of functional sterility it is important to rule out any evidence of organic disease, not only on the part of the female but also on the part of the male member of the couple. Both husband and wife must undergo a thorough physical examination. The wife, in addition to a routine pelvic examination, must undergo a Rubin test or a salpingogram or both. The husband must have a urological study and sperm analysis in order to evaluate his status in the problem. It is only after the husband is found to be fertile and the woman's pelvic organs are found to be normal, with the tubes patent and capable of normal peristalsis, that the patient is subjected to further laboratory studies in order to determine the presence of endocrine dysfunction.

We employ the following diagnostic tests for evaluation of the patient's endocrine status: (1) basal metabolic rate test; (2) blood studies for the estimation of cholesterol and urea nitrogen; (3) glucose and insulin tolerance tests; (4) endometrial biopsies (premenstrual or weekly); (5) vaginal smears; (6) hormonal assays of the urine for the excretion of pituitary gonadotropins, 17-ketosteroids, and estrogens; (7) roentgenologic studies, including the skull, sella turcica, and long bones, intravenous pyelography, and perirenal insufflation with laminography when possible. The exact indications for these laboratory adjuncts will be discussed under each gland separately.

Dr. Finkler is Chief, Department of Endocrinology, and Dr. Becker is an Assistant on the Endocrine Staff, Newark Beth Israel Hospital, Newark, New Jersey.

OVARIAN FACTORS IN STERILITY

Although the ovaries constitute only one link in the chain of endocrine glands concerned with fertility, it is by far the most important link. The primary requisite for female fertility, after all, is an ovary capable of producing mature graafian follicles with subsequent ovulation and luteinization. Failure of the ovary to perform these functions leads to sterility. This failure may be primary, due to intrinsic ovarian deficiency, or secondary, due to failure of other endocrine glands to exert their normal influence on the ovaries.

Primary ovarian failure is a congenital defect ranging in severity from ovarian agenesis to borderline cases of ovarian immaturity. The history is invariably one of primary amenorrhea. General physical examination usually reveals a hypogonadal body configuration, and pelvic examination may reveal hypoplastic or cystic ovaries with hypoplastic genitalia. The vaginal smear may show deficient development of the vaginal epithelium as manifested by the absence of mature squamous epithelial cells. Endometrial biopsy may show a resting or atrophic endometrium. Urinary studies may reveal an increase in the pituitary gonadotrophins.

Severe primary ovarian failure with primary amenorrhea does not respond to either hormonal or radiation stimulation. Lesser degrees of ovarian immaturity, however, may respond to such stimulation, and menstrual periods and fertility may

Fig. 1. **Case I, T.W., Age 26. Secondary ovarian failure. Note facial hypertrichosis.**

Fig. 2. **Note change in facial expression and disappearance of hypertrichosis in Case I.**

be established. It is important to remember that awakening of the ovarian function may not yield the desired results unless the uterus and fallopian tubes are sufficiently developed to be able to respond to ovarian stimulation. It is, therefore, imperative to use estrogens and progesterone cyclically, in order to promote growth and development of these organs, prior to initiating therapy for ovarian stimulation. This method has been described in previous publications.[1,2]

Secondary ovarian failure, due to systemic disease, nutritional factors, or pelvic infection, frequently results in ovarian degeneration with sclerosing processes in the capsule and interstitial tissue with multiple cyst formation. Cystic ovaries may also occur congenitally. These cystic follicles crowd and encroach upon potentially normal follicles, thus preventing their maturation. In the diagnosis of this condition a past history relating to causes of ovarian degeneration in a patient with secondary amenorrhea is important. Confirmatory laboratory tests should be carried out as a matter of course. The only approach to this type of ovarian disease is surgical resection of the cystic ovaries with the hope that normal tissue, if present, will have the opportunity to develop and function. Results from this procedure are encouraging and successful in a fair percentage of cases.[2]

CASE I: (Secondary Ovarian Failure). T. W., age 26, married 5 years. Chief complaints: Sterility, amenorrhea of 7 years' duration, hypertrichosis of the face, chest, and extremities, and obesity (Fig. 1). Menstrual history: The menses were established at the age of ten and a half years. They occurred at first once a year and later once in 3 years. There was a total of only five or six periods with no menstruation occurring, normal in size and position. Both ovaries were enlarged and somewhat tender. Hormonal and radiologic studies did not reveal any outstanding abnormalities.

A laparotomy revealed the uterus and the tubes to be normal; but both ovaries were greatly enlarged and contained multiple follicle cysts (Fig. 3). Palpation of both adrenal regions revealed no adrenal enlargment or tumor. A wedge resection of the ovaries was carried out and appendectomy performed. Following the operation, menstrual periods were re-established and marked diminution in hypertrichosis occurred (Fig. 2). The patient conceived within a few months after operation and was delivered at term of a normal child. The menstrual periods continued to be regular after delivery.

Fig. 3. Section of a wedge-shaped excision of one of the ovaries of Case I. Note large follicle cysts.

Pituitary Factors in Sterility

The pituitary-gonadal relationship has been the subject of the earliest investigations in the field of endocrinology by such great pioneers as Smith, Engle, Evans, Aschheim, Zondek, Fevold, Flumann, and others. The result of these investigations has been a clear demonstration that the gonadotropic function of the anterior pituitary is a complex process which depends on the production of various fractions of the gonadotrophic hormones. These fractions are: follicle stimulating hormone, ovulation hormone, luteinization hormone, lactogenic hormone, and possibly an ovary interstitial cell stimulating hormone. These hormones must be produced in proper amounts and in proper sequence in order to achieve the ideal gonadotropic effect on the ovary. Even if such an optimum relationship does exist, ovulation and luteinization is possible only in the presence of normal graafian follicles capable of responding to such stimulation. Unfavorable genetic, nutritional, and constitutional factors may limit the range of ovarian response. These detailed factors cannot be discussed within the scope of this paper. They must be taken into consideration in the course of analysis of the problems of a sterile couple and they must be dealt with accordingly. Psychogenic factors also constitute an important and powerful element in the pituitary ovarian relationship. Amenorrhea and functional sterility are frequently traced to shock and emotional conflicts.[4] Psychoanalysis and psychotherapy applied to suitable cases have resulted in spectacular cures. Since this presentation must be limited to the discussion of hormonal relationships only, we will now consider the effect of the anterior pituitary on sterility.

Pituitary Hypofunction

Pituitary hypofunction may be either a complete panhypopituitarism involving growth, gonadotropic, and adrenotropic functions of the organism, or it may be limited to the deficient gonadotropic function alone. Pan-hypopituitarism is not amenable to treatment so far as sterility is concerned, and we will, therefore, limit ourselves to consideration of patients who present the picture of pituitary gonadotropic deficiency. Physically these patients are of normal or above normal height, with trunk obesity, thin ankles and wrists, and scanty pubic and axillary hair. Periods of amenorrhea may alternate with periods of irregular spotting. Sterility is usually of 2 to 8 years' duration. The laboratory diagnosis is made on the following findings: (1) low urinary gonadotropin; (2) abnormal endometrial pattern; (3) low basal metabolism and lowered specific dynamic action of the proteins. The therapy consists of weight reduction by the use of a high protein, low fat, low carbohydrate diet, and the use of pituitary and chorionic gonadotropins sequentially or combined. Gonadotropin therapy must be used with considerable judgment, as large doses over a prolonged period of time may result in the formation of antigonadotropin factors. These antihormones nullify the effect of the gonadotropin and thereby defeat the very purpose for which they were used.

Small dose radiation therapy to the pituitary and ovarian regions administered by a standard technique is superior to hormonal therapy, resulting in a higher percentage of favorable responses. It is also less time-consuming and less expensive. Radiation therapy is still not generally accepted by the public and the profession. Many clinicians feel that the far-reaching effects of radiation

therapy are still unknown. The general tendency is to attempt hormonal therapy first and to resort to radiation therapy only when hormonal therapy fails. In our series of 160 cases of functional sterility, 83 had radiation therapy and 77 had hormonal therapy. In our experience hormonal therapy resulted in 34.2 percent of pregnancies, and radiation in 41 percent. The technique of hormonal and radiation therapies has been previously described.[2,5]

Pituitary Hyperfunction

Pituitary hyperfunction as a possible etiological factor in sterility is usually confined primarily to pituitary adenoma either of the eosinophilic or the basophilic type. It is to be remembered that pituitary hyperplasia during the reproductive period of life may occur as a secondary manifestation of adrenal cortical hyperplasia and as such will be considered under that heading.

Eosinophilic adenoma does not always cause secondary amenorrhea and sterility. Although many patients present acromegalic features, with large hands and feet, they may menstruate regularly and bear children. In these patients pituitary adenoma, roentgenologically demonstrable, may have been arrested in its growth and may not produce pressure atrophy on the gonadotrophic elements of the anterior pituitary. An actively growing adenoma, however, may produce pressure atrophy on the rest of the anterior pituitary gland causing amenorrhea and sterility. This tumor usually stimulates the adrenal cortex and may cause excessive production of the 17-ketosteroids, facial and body hypertrichosis, and further hormonal imbalance and sterility. The diagnosis is made by the typical appearance of acromegaly, increasing size of hands and feet, changes in the visual fields, when pressure on the optic chiasm exists, and by the roentgenologic findings of an enlarged sella turcica.

The urinary gonadotropins are usually decreased and there is usually an increased urinary excretion of 17-ketosteroids. The treatment consists of several courses of deep radiation therapy to the region of the pituitary in conjunction with estrogens administered for the purpose of further inhibition of pituitary overactivity. The estrogens also serve to counteract the excessive production of androgens by the adrenal cortex.

CASE II: (Sterility Associated with Eosinophilic Adenoma). S. A., age 32, married 7 years. Chief complaints: Headaches, lack of energy, secondary amenorrhea, and sterility. Menstrual history: The menses were established at the age of 14, were regular at first, but later occurred only every 2 to 3 months. Physical examination: Height, 63 inches; weight, 135 pounds; blood pressure, 140/90 mm. hg. The patient presented typical acromegalic facies with edema of the eyelids and lips, and large hands and feet out of proportion to the other body measurements. There was hypertrichosis of the trunk and extremities. The fundi were negative but there were contractions of the visual fields indicating a lesion of the optic tract. No abnormalities were found on pelvic examination. Roentgenologic studies of the skull and sella turcica showed a ballooning of the sella with a moderate decalcification of the dorsum sellae. The basal metabolic rate was +18 percent. A glucose tolerance test showed a diabetogenic curve.

A diagnosis of pituitary adenoma was made and the patient received a course of radiation therapy to the region of the pituitary gland. Another course was given two months later because of continued headaches and menstrual irregularities. Although regression of the tumor was noted after radiation therapy, secondary amenorrhea and sterility still persisted one and a half years later. It was decided, therefore, to supplement radiation therapy with hormonal therapy for the purpose of further inhibition of the pituitary overactivity. The patient received stilbestrol 0.5 to 1.0 mg. twice daily, at regular intervals for one year. The therapy was so regulated as to allow for intervals of withdrawal bleeding. The patient responded favorably by regulation of her menstrual periods, increase in energy, and decrease in intensity of the headaches. At the end of one year of therapy the patient conceived and was delivered of a normal viable child.

Basophilic adenoma or overactivity of the basophilic cells of the anterior pituitary always results in amenorrhea and sterility. It is the basophilic cells of the anterior pituitary which are concerned with the production of the gonadotrophic hormones. Pathologic changes in these cells and tumor formation completely disrupt the pituitary-gonadal relationship and cause other severe systemic disturbances. These are manifested by disturbed carbohydrate metabolism, polycythemia, and faulty nitrogen metabolism with osteoporosis and secondary changes in the adrenal cortex. Physically, the patient presents typical characteristics, such as, generalized purplish skin discoloration, "moon face," buffalo-type of trunk obesity, purplish striae, hypertrichosis, kyphosis, and hypertension. There may or may not be any visual changes. The diagnostic laboratory tests consist of (1) lowered glucose tolerance; (2) increased urinary 17-ketosteroids; (3) polycythemia; (4) negative nitrogen balance. The roentgenologic studies show osteoporosis, particularly of the spine. The sella turcica may or may not show any evidence of an adenoma.

Treatment consists of several courses of deep x-ray therapy to the region of the pituitary. In advanced cases of osteoporosis intensive therapy with testosterone compounds is beneficial by causing nitrogen retention and recalcification of bone. This therapy further increases hypertrichosis, how-

ever, and is not necessary if radiation therapy is applied early and found to be successful.

In our experience true basophilism is an extremely rare condition. In addition these patients are notorious for their sterility. None of our patients ever conceived.

Thyroid Factors in Sterility

Diseases of the thyroid gland profoundly affect the menstrual function and fertility.[6] In hypothyroid states menorrhagia is common, although amenorrhea also occurs frequently. In hyperthyroidism, especially in exophthalmic goiter, amenorrhea is more common than menorrhagia. In either case, normal ovarian function is profoundly disturbed and infertility may occur. Correction of the disorder frequently re-establishes the normal cycle and fertility.

CASE III (Hypothyroidism and Sterility). F.G., age 27, married 3 years. Chief complaint: Sterility of 3 years' duration. Menstrual history: The patient had secondary amenorrhea since the onset of puberty at the age of 14. Periods occurred at 2 to 6 month intervals. The last menstrual period occurred 2 months prior to the first examination. Patient had received estrogenic therapy for secondary amenorrhea for 2 years without results. The physical and pelvic examinations did not reveal any abnormalities. The Rubin test revealed normal tubal patency and peristalsis, the Huhner test was negative; and examination of the spermatic fluid was satisfactory as far as number, motility, morphology, and endurance was concerned. The basal metabolic rate was —19 percent. The pregnancy test was negative. The patient was placed on desiccated thyroid substance 0.5 grains twice a day. The patient had an amenorrhea of 2 months' duration when therapy was begun. At the end of another 2 month period there was still no menstrual flow. The pelvic examination at that time revealed the uterus to be slightly enlarged and there was evidence of a bluish discoloration of the cervix and vaginal mucous membrane. The Friedman test was positive for pregnancy, and the patient progressed normally, from an obstetric point of view.

This case illustrates a rapid response to thyroid medication, as pregnancy probably occurred within 2 to 3 weeks from the initiation of therapy.

Adrenal Factors in Sterility

The adrenal cortex, indispensable to life, secretes many adrenal-cortical hormones and cortical steroids. These hormones are vitally concerned in maintaining blood volume, blood pressure, carbohydrate metabolism, sex maturation, and fertility. The relation of the adrenal cortex to the gonads has been the subject of investigation by many eminent research workers. Some of the evidence is rather conflicting. Implants of adrenal-cortical tissue and the administration of adrenal-cortical extracts to experimental animals has markedly stimulated the growth of the ovaries in some animals and caused cystic degeneration and atrophy with the suppression of estrous in others. In the human, overproduction of the adrenal-cortical hormones, particularly the androgens, causes virilism, amenorrhea, and sterility. The severity of the disturbance depends, of course, on the degree of adrenal-cortical hyperplasia, the most severe cases being those with adrenal-cortical tumor.

In our series of 160 cases of functional sterility, 11 presented signs and symptoms of adrenal-cortical hyperplasia, the final diagnosis being made by the estimation of 17-ketosteroid excretion, the x-ray visualization of the adrenal glands, and the disturbed carbohydrate metabolism. In adrenal-cortical hyperplasia or tumor, there is a marked tendency to decreased glucose tolerance. Although there is a depression of gonadal activity, the vaginal smear frequently shows adequate cornification because the adrenal cortex is a rich source of estrogen production. In our series of 11 cases, combined hormonal and radiation therapy resulted in conception in four patients.

CASE IV. (Adrenal Cortical Hyperplasia and Sterility). S. F., age 32, married five and one half years. Chief complaints: Headaches, hypertension, obesity, hypertrichosis, sterility, and amenorrhea of 5 years' duration.

Menstrual history: Menses began at the age of 11, and occurred regularly till the age of 16, after which the interval increased to 2 and 3 months. Shortly after marriage menstruation was not re-established and remained absent for 5 years. Physical examination: Height 64½ inches; weight 191 pounds (a weight gain of 67 pounds in 5 years). The obesity was typical buffalo-type, the coloring of the face and neck was of a purplish hue; there was moderate facial hypertrichosis, but it was more pronounced on the chest, abdomen, and extremities. The blood pressure ranged from 180/130 to 200/130. The breasts were well developed; no masses were palpable in the abdomen; and no abdominal striae were noted. The pelvic examination revealed normal pelvic organs. There was no evidence of an enlarged clitoris.

Laboratory investigation: The glucose tolerance was markedly decreased as evidenced by a diabetogenic curve; the blood chemistry studies were within the normal range, except for a moderate elevation of the blood urea nitrogen (32 mg.); the basal metabolism was —4 percent. The complete blood count showed a tendency to hemoconcentration. The Wassermann test was negative. Urinalysis, kidney function tests, peri-renal insufflation, and intravenous pyelogram were all normal. X-ray studies of the skull, sella turcica, and thorax were also negative. The estimation of the 17-ketosteroids showed the excretion to be 12 and 14 mg. per 24 hours on two occasions (upper limit of normal); a qualitative fractional analysis,* however, showed a moderate elevation in the second fraction (beta fraction). According to Dinge-Manse,[7] it is indicative of adrenal-cortical hyperplasia.

The extensive qualitative analysis of the 17-ketosteroids, the hemoconcentration, the glucose tolerance test, and the clinical findings confirmed the original impression of adrenal-cortical hyperplasia.

Therapy: It was decided to put this patient on hormonal therapy. Synthetic estrogens, ethinyl estradiol,† 1.0 grain, was administered three times a day, from April 22 to May 27, 1946; the first period in 5 years occurred on May 31, 1946. The patient also

reported that she was feeling much better; there was an improvement in the headaches; and the blood pressure ranged from 160/98 to 180/120. Estrogen therapy was resumed in June and continued with intervals of rest to September, 1946. The patient's headaches disappeared almost completely and there was a lowering in the blood pressure and diminution in the facial and chest hypertrichosis. Monthly menstrual periods were re-established, but later became profuse and were accompanied by cramps and nausea. Estrogen therapy was discontinued and an attempt was made to achieve a partial suppression of adrenal-cortical hyperactivity by deep radiation therapy. This was carried out during October and November, 1946. Radiation therapy had little effect on the amenorrhea, although there were periods in October, 1946, and in January, 1947. The estimation of the 17-ketosteroids carried out in February, 1947, showed a considerable drop from 12 to 14 mg. per 24 hour specimen to 4.39 mg. There was also a moderate improvement in the glucose tolerance curve. Moderate dietary restrictions and small doses of dexedrine sulfate resulted in a gradual loss of weight. The purple hue of the skin also disappeared. There was no further diminution in the hypertrichosis and the patient asked permission to resume estrogenic therapy. After amenorrhea for 2 months, estrogen therapy was resumed and continued at intervals with improvement in menstrual cycles. In August, 1947, after a 2 week delay in the period, the patient had profuse uterine bleeding, and a D & C revealed an incomplete abortion. Although the patient regretted the loss, she continued to improve as far as headaches, hypertension, and weight loss were concerned. Estrogen therapy was discontinued but she reported regular menses for one year. She was seen again in March, 1949, when a diagnosis of pregnancy was made again. Although she regained a considerable amount of weight and a rise in blood pressure recurred, she was extremely happy with this second pregnancy. Unfortunately, in spite of estrogen therapy administered during pregnancy, another miscarriage occurred after the completion of 4 months of gestation.

The case herein presented was diagnosed as Cushing's syndrome due to adrenal-cortical hyperplasia. Intensive estrogen therapy re-established her menstrual periods after a five years' amenorrhea. There was also a marked diminution in hypertrichosis and hypertension. Deep radiation therapy to the regions of both adrenal glands depressed the excessive secretion of adrenal-cortical hormones and resulted in two pregnancies which terminated in miscarriages. Re-evaluation of the patient's hormonal status is now in process and partial adrenalectomy is under consideration on the completion of these studies.

*The fractional analysis on both occasions was carried out by Dr. E. Dinge-Manse of the Pharmaco-Therapeutic Laboratories of the University of Amsterdam, Holland.

†Ethinyl estradiol, as tablets "Lynoral," was supplied by the courtesy of Dr. B. J. Brent of Roche-Organon, Inc., Nutley, New Jersey.

Pancreatic Factors in Sterility

Whereas diabetes is usually not considered as a cause of sterility, we have encountered several cases where control of the diabetic state resulted in conception.

Conclusions

1. Endocrine disturbances play an important role in the problems of sterility in the female.

2. In a series of 415 cases, 160 were directly attributable to endocrine dysfunction.

3. All of the glands of internal secretion may be involved and a detailed analysis will indicate the primary disturbance.

4. Correction depends upon adequate diagnosis and institution of appropriate therapy.

References

[1]Finkler, R. S., and Bass, R. D., Primary amenorrhea, M. Woman's J. **47:** 1, Jan. '40.

[2]Finkler, R. S., Evaluation of hormonal and radiation therapy in 190 cases of functional sterility and secondary amennorrhea, preliminary report, Am. J.Obst.&Gynec. **58:** 559-564, Sept. '49.

[3]Stein, I. F., Cohen, M. R., and Elson, R., Results of bilateral wedge resection in 47 cases of sterility; 20 year end results, Am.J.Obst.& Gynec. **58:** 267-274, Aug. '49.

[4]Whitacre, F. E., and Barrera, B., War amenorrhea; clinical and laboratory study, J.A.M.A. **124:** 399-403, Feb. 12, '44.

[5]Finkler, R. S., Treatment of endocrine infertility in female M. Woman's J. **55:** 27-32, Oct. '48.

[6]Mason, L. W., Hypothyroidism and its relation to gynecologic problems, West. J. Surg. **55:** 338-342, June, '47.

[7]Dinge-Manse, E., Personal communication.

RECENT ADVANCES IN MEDICINE

Progress in Psychiatry

Zelda Teplitz, M.S., M.D.

Psychiatry probably has advanced more in the last ten years than almost any other specialty of medicine. The war merely accelerated an already existing trend. Medical students are quick to sense this trend, like all young people. I have been told that, although in the thirties almost half the members of entering classes in medical schools were interested in becoming surgeons, to become a psychiatrist is now the conscious goal of an equal number at admission. Not only this changed attitude of the student, but also the interest of the public for psychiatric information makes it important that the non-psychiatric physician keep up with new developments in psychologic medicine. During the war, psychiatry was officially made a field on a par with medicine and surgery in the Surgeon-General's office. The Federal Government has passed a National Mental Health Act to extend psychiatric facilities and promote training and research, and the flood of movies, books, and articles on psychiatry proves the great public interest and support.

The teaching of psychiatry in the medical schools has changed.[1] Previously psychiatry was taught in the clinical years on a par with specialties, such as dermatology, orthopedics, ophthalmology, which were differentiated from one another on the basis of structural concepts stemming from the Virchow pathologic anatomy tradition. Emphasis was placed on the diagnoses and on mental status interviews. The subject matter was presented in terms of recognizable disease patterns. The goal was to sort these from the organic diseases. Then the psychiatric cases were sent to a special hospital. Today, however, the psychiatric approach is taught, understanding any patient as a person who is sick. In hysterical paralysis of an arm, not only the paralyzed arm must be studied—comparable to any diseased organ—but also the pathogenesis, i.e., the psychodynamic process—comparable to the predisposing and precipitating causes. The psychiatrist is being utilized to determine the psychologic factors in any patient, not merely to separate the "psychos." In this way, the traditional isolation of psychiatrists from other physicians is lost. This working together of psychiatrist and other physicians was seen especially in military hospital work. There psychiatrist and non-psychiatrist personnel had to work together on the same cases diagnostically and therapeutically. All groups were benefited, including the patients.

In this review psychosomatic medicine will be taken up first. Progress in psychiatry dealing with the psychotics will follow; this will touch only on the shock therapies, lobotomy, and institutional aspects since the psychotherapeutic aspects in which she pioneered have already been discussed by Dr. Fromm-Reichmann in the JOURNAL (August, 1949). A discussion of modifications in psychotherapy such as narco-synthesis (narco-analysis), hypno-analysis, group therapy, and brief therapy will follow. Child psychiatry then will be discussed. Finally some of the social applications of psychiatry to crime and delinquency, race prejudice, and geriatrics will be mentioned.

Dr. Fromm-Reichmann reviewed recent advances in psychoanalysis. She briefly and clearly summarized the fundamental concepts, the basic theory of personality development, normal and abnormal. For those who wish to read further, Benedek[2] and Alexander[3] offer authoritative yet easily understood

Dr. Teplitz is Clinical Assistant in Pediatrics, Cook County Hospital, Children's Division, Chicago, Illinois.

descriptions of contemporary psychoanalytic understanding of the forces at work in determining personality and character, that is, psychodynamics. The encyclopedic book by Fenichel[4] should be mentioned, too, although it is more valuable for those with previous knowledge of the field as a reference work on specific subjects. It must be emphasized that without this psychodynamic understanding, the "physiology and pathology" of personality, no rational understanding of diagnosis and therapy is possible.

Psychosomatic Medicine

For the non-psychiatric physician clarification of emotional factors in diseases formerly considered outside the province of psychiatry is a most significant development. Peptic ulcer, asthma, hypertension, arthritis, disturbances of the female sexual cycle, and other diseases have been carefully studied in research, especially at the Chicago Institute for Psychoanalysis; and a series of reports, now classical, have been published. The specific emotional constellations have been described in cases studied concurrently by the analyst with other specialists of the particular disease. Recent work has been extended to ulcerative colitis and diabetes. Most of the recent papers were collected and published last year.[5] French and Alexander's studies on asthma[6,7] and Benedek's study of sexual cycle in women,[8] both landmarks in the field, have been published as monographs under the sponsorship of the National Research Council. At Columbia University, too, Dunbar[9] has published much work attempting to correlate personality types with various disorders. She has also attempted to correlate various social and personality factors with disorders such as coronary heart disease and accident-proneness.

In peptic ulcer, especially in men, the emotional constellation seems to be a conflict of intense ambition on the surface together with strong chronically frustrated dependent wishes which the individual does not acknowledge to himself because of pride. Ulcerative colitis, not as clear, is felt to be related to the patient's being chronically under strong eliminative and retentive emotional pressures. In asthma, psychologic factors precipitating the attack were found to be rather specifically related to a verbally unexpressed cry or speech to the mother. The attack was seen as an equivalent to danger of losing the mother, often because of forbidden impulses to be confessed.

In essential hypertension an unconscious readiness for rage in outwardly calm patients was seen. More recent work in progress in rheumatoid arthritis has found that arthritis which tends to develop in women with chronically inhibited hostility is relieved by much bodily activity and an excessive need to serve others. When this characteristic method of discharge is interrupted the arthritis is in some way precipitated.

Headache has been studied by Wolff of Cornell with special reference to neurophysiology. He feels that tension headaches constitute 90 percent of the problem.

Excellent reviews of recent work in this psychosomatic field are available in Alexander and French,[5] Weiss and English,[10] Levine[11] and Alexander.[40]

The Psychoses

Progress in psychiatry of psychoses has developed along two routes. The introduction of shock therapies, first metrazol and insulin, now electric shock, led to much research on brain physiology in attempts to clarify the alteration of physiologic function postulated to account for the shock therapy results. The initial great enthusiasm has given way to caution, so that warnings against indiscriminate use have been given again and again by leaders of the specialty, those who are most familiar with utilizing the shock treatments. All these procedures must be given accompanied with individual psychotherapy, and occupational, physical, and environmental therapy, so that the cause of the disease and not only its symptoms are removed. However, there still seems to be no general agreement on the physiologic basis of shock therapy results.

Insulin treatment is considered by some still to be the most effective non-psychoanalytic treatment for schizophrenia. Because of the high cost in time and specially trained personnel required for insulin therapy, convulsive therapy in the form of electric shock has been entirely in the foreground. Metrazol convulsions are rarely used.

Electric shock therapy as originally given with alternating 60-cycle current is still standard. No adequate theory of its mode of action is known, but all evidence is that it operates on a symptomatic rather than an etiologic level. Because of apparent ease in administration, many warnings have appeared that it should be given only by psychiatrists trained in the procedure and trained in the discriminating selection of cases. It should be administered only as part of an over-all treatment program, including psychotherapy. It is best given

in a psychiatric hospital. However, very carefully-selected patients may be treated on an ambulatory basis in hospital out-patient departments and clinics or in private office practice by psychiatrists of much experience in its use. Complications of fractures occasionally occur. Indications are as follows: The affective disorders and the severe depressions (such as involutional melancholia, agitated and reactive depressions, depressed phase of manic-depressive phychosis) respond best, in that the course is shortened. Individual manic episodes and schizophrenias, especially the acute catatonias, also respond, although less well than the first group. For neurotics, electric shock therapy is not only valueless, but is often harmful, since it may mobilize dangerous psychologic symptoms. Paranoids and hypochondrial patients of the older age groups do not respond well, and are sometimes made more difficult to handle. The ease of what an intern called the "button treatment" and the wide publicity often cause the patient's relatives and sometimes even the patient to demand of the physician treatments which may be expensive and useless, after time even decreases the suggestive effect which is seen in any dramatic treatment. Discouragement of the patient and relatives makes rational etiologic treatment more difficult subsequently.

The most recent of the "organic" therapies is pre-frontal lobotomy, cutting the white fibers which course to and from the frontal lobes and the thalamus. Still newer procedures are lobectomy (amputation of the frontal lobes) and topectomy (removal of cortical areas supposed to give rise to frontothalamic radiations). Although a great deal has been written, and more than 5,000 patients have undergone these operations, few conclusions can be drawn since most of the cases have not been studied adequately from a scientific standpoint. It seems generally agreed, however, that only psychiatric cases not responding to other treatments should undergo lobotomy, since permanent deleterious psychologic results have been proved to follow. The operation has seemed to benefit patients with intractable pain of organic origin. It should be emphasized that the operation is not a specific and requires, as do all the "shock therapies," a complete psychiatric therapeutic regime.

Opposed in some ways to these so-called organic "physiologic" therapies for psychoses are trends in therapy which depend upon our increased understanding of the interpersonal aspects of the psychotic. Psychoanalytic psychotherapy has been applied to psychotics by analysts, Fromm-Reichmann and Sullivan in Washington,[12] and more recently by Rosen[13] in New York.

The inadequate public psychiatric hospital treatment of psychotics in the past few years has received much public attention in novels, the cinema, and essays in popular periodicals. Overcrowding (20 to 74 percent[14] shortage of personnel, especially those adequately trained), is extreme. The significant developments in methods of individual treatment have outstripped the environmental facilities available for intramural care. In addition to the therapies mentioned above are group therapy discussion, dramatization of conflict situations, family education, recreational and occupational therapy, volunteer services. The training of nurses and attendants as the responsibility of the psychiatrist[15] has been made the subject of an excellent teaching outline by Dr. William C. Menninger, head of army psychiatry for the armed services during the war.

Brief Psychotherapy

The need for shorter, more flexible psychotherapeutic methods was stimulated enormously by the war, by the great number of both military and civilian patients requiring treatment. As a result, methods applying the psychoanalytic principles together with hypnotic drugs, or hypnosis, were evolved to shorten the period of treatment. Group therapy, also, though not as spectacular, was attempted and studied by serious workers.

The Brief Psychotherapy Council meetings, under the sponsorship of the Chicago Institute for Psychoanalysis, summarized much of the work throughout the country.[16,17] In modification, selected cases of long-term intensive psychoanalysis by flexibility of procedures, decreasing frequency of interviews, and interruption when indicated, was made the object of a seven-year cooperative research by the Institute, which in 1946 published a much-heralded book of theoretical discussions and case reports.[18]

Hypnotic drugs for diagnostic aid had been routinely used by many psychiatrists for a long time, but modification of the patient's ego state by barbiturate drugs during treatment was practiced extensively by psychiatrists in service. Earlier workers had used other drugs. Horsely in 1936 described the therapeutic technique using nembutal.[19] In the Air Corps, Grinker and Spiegel applied the "narco-synthesis" method to short term combat neuroses.[20,21,22] The following is described by them as taking place under the treatment: (1) release

of the unconscious tension, abreaction; with (2) positive dependent feeling for the therapist and identification with him; (3) desensitization from memories of anxiety-producing situations by the therapist helping the patient to learn and discriminate between past anxiety and present reality and safety; (4) decrease of guilt and sense of inferiority; (5) achievement of insight between neurotic reaction and unconscious character reactions; (6) encouragement of maturity and independence from therapist. Only steps (1) to (3) were carried out under the repetitive narcosis, the rest while the patient was conscious. Release of emotion was not enough. Cases responding best in the brief period were free-floating anxiety states, conversion hysterias, phobias, and some mild depressions. Psychosomatic visceral disturbances, compulsions, rigid hostile character disorders, cases with paranoid trends, and depressions following loss of a comrade, usually did not improve in the forward areas, but the authors felt that many of these cases required more time to "work-through" to recovery in realistic behavior,

The authors definitely feel that usually they did not alter the patient's fundamental personality with the brief treatment. They felt the techniques required a thorough knowledge of the dynamic forces at work in human personality.

The method has been applied to civilian neuroses with results less successful, since many civilian neuroses are not of the type with one anxiety-evoking situation which can be abreacted, but are chronic neurotic character disorders.

Hypnosis has had a renewal of interest by medicine since the war, probably as a result of the narco-synthesis work. "Hypnotherapy," "hypnosynthesis," refer to procedures similar to narco-synthesis. The use of hypnosis in anesthesia has been widely discussed by the public, non-medical as well as medical therapists. Studies at the Menninger Foundation by Brenman and Gill[23] have been significant theoretical advances. The important factor in hypnosis seems to be replacement of the child-parent emotional relationship by the adult patient-physician relationship. It should be emphasized that correct diagnosis and understanding of pathogenesis is just as necessary with psychiatric as with other medical cases. Many non-medical practitioners have always used suggestive procedures, with varying results. Results with hypnosis, unless based on a rational conscious understanding of the psychodynamics, that is "pathogenesis," will accomplish no more than other kinds of suggestive treatment.

Group therapy also has received a stimulus from the war-time need, and also has benefited from introduction of dynamic psychoanalytic concepts. Understanding of the basis of the interrelationships of leader and group has increased. Thomas,[24] Slavson,[25] and Ackerman[26] have collected much of the literature.

Child Psychiatry

Psychologic factors of medical practice with children have been intuitively recognized by physicians, more so than with adults. A child will react and adapt to intolerable home tensions by disturbances in behavior or in mental functioning, or with expressions of tension in disturbed physiologic function. The most common are eating disturbances, (vomiting, bulimia, anorexia), or eliminative disorders, (diarrhea, enuresis, constipation), sleeping disturbances, (insomnia), and interpersonal total behavior disturbances, (restlessness, crying). The great importance of the interpersonal relationships of the parental attitude has been recognized in pediatric practice, although sometimes not acknowledged in scientific research in pediatrics.

Recent psychiatric advances in this field have been made in the understanding of fundamental normal personality growth process in development. Personality development is seen to be dependent on "emotional nurture" from the parents, at first especially from the mother. Both security and stimulation to grow at proper age levels are needed. While developmental scales from one to twelve have been worked out in detail by Gesell[27,28] in numerous books and papers, the relationship of development to emotional disturbance within the family is important in therapy.[29] These psychosocial, interpersonal aspects of development of children have recently been summarized in dynamic terms by Josselyn in a convenient easily read form with an excellent bibliography.[30]

More than anything else child psychiatry has tended to stress the interrelationship of parent and child. Benedek's summary of the family emotional constellations and the interaction of mother's, father's, and infant's personality growth patterns are of great importance in getting a perspective on the needs of each for the other.[31] The rooming-in plan for the mother and newborn is arousing much interest as a means of helping with the mother's feeling of strangeness toward her new child. In collaborative psychotherapy by separate psychiatrists, the mutual "lock and key" neurosis of parents and child was described.[32] In child guidance clinics and social case work agencies, collaborative therapy by psychiatrists and social workers is the rule. The clinic is usually a center for

professional training as well as a diagnostic service and treatment center and the "psychiatric team" is the rule. However, well trained child analysts familiar with manifestations of the transference and the interplay of parent and child with one therapist often work with greater flexibility and economy of time with both parent and child.

The great extension of nursery schools, while not psychiatric, should be mentioned here, since parents often attempt to use them to make up for serious deficiencies in the home.

Some of the outstanding publications of general interest in the field of child psychiatry have already been given as references. The books by Anna Freud[33,34] should be mentioned as classic works. Spock's book for mothers reprinted in an inexpensive Pocket Book contains useful psychiatric suggestions given in a way which does not make mothers too anxious and guilty. Outstanding books which should be mentioned are those by Pearson[35] and Witmer.[36]

The use of phychiatrists as consultants in family welfare agencies is a development having widespread social implications. The social agencies are of various types, such as family counseling case work, child welfare, foster home care, and institutional care. Institutional care is increasingly given to children for various reasons, not only economic, but also including emotional disability as well as physical disability of the child. An interest in residential in-patient psychiatric treatment centers for children is beginning.

Social Psychiatry

Delinquency prevention and treatment is an important function of child psychiatry, since children often are brought to the psychiatrist's attention when they become anti-social. In delinquency the patient's conflicts are often with society's standards rather than with his own conscience or values, as is true in the neuroses. However, numerous neurotic delinquents and criminals of the type described by Alexander may partially "act-out" with society their intrapsychic conflicts in such a way that their neurosis is maintained in a cycle of recurring punishment which satisfies underlying intrapsychic guilt due to neurotic conflict. Papers by Szurek[37] and Levine,[38] and recent books by Friedlander[39] and Eissler as editor[40] give a good summary of theoretical factors in diagnosis and treatment. In this field, however, real treatment is extremely inadequate and lags far behind theory, except in terms of child psychiatry. The largest part of the therapeutic task must be social rather than medical.

Interesting application of concepts of psychosomatic disease to the illness of social groups (psychosocial medicine) has been made by Halliday in a study of sick society.[41] He brings out the relationship between social frustration and bodily disease, that is, external social frustration leading to tension discharged through internal bodily organs. In a sense, this is the opposite of neurotic delinquency in which internal frustration is discharged upon society.

The changing relationships of the sexes have been widely discussed in popular as well as more serious studies. The public sensation over the "Kinsey Report" has seemed to die down. Many scientific comments on it have been published in critical reviews and essays, even in the pocket book field. One of the most significant discussions of the report has been made by a novelist, Trilling, and reprinted in a medical journal.[42] More recently, a work written from a different viewpoint by a noted woman anthropologist, Margaret Mead, gives promise of becoming a real classic in the field.[43] It seems almost "must reading" for women physicians who in their own lives often objectify her findings. Insight into a patient's social and sexual problems will be greatly increased for the physician reading this book and treating the patient, not the disease.

Students of the social problem of prejudice, especially race and religious prejudice, have increasingly turned to dynamic psychiatrists to learn analytic insight into the basic irrational and unconscious motivations of discrimination and conflict. McLean[44] summarized her studies in the field of the Negro-White problem. The white man projects his own neurotic unconscious weakness to the Negro, who then becomes the outlet for the white man's own conscious pent-up frustrated hostility. The conscious real discrimination suffered by the Negro often is utilized unconsciously and neurotically by him to rationalize his hostile aggressive protest against unconscious passive longings which are not openly admitted because of pride and guilt. Similar psychological factors in anti-semitism were studied and summarized in important papers by Ackerman and Jahoda.[45,46]

Concepts of mental health and the responsibility of psychiatrists in society were main topics at the first International Congress of Mental Health in 1948. In 1946, a dynamically trained psychiatrist, Dr. Brock Chisholm, then Deputy Minister of National Health in Canada and now the head

of the World Health Organization, soberly but brilliantly pointed out the responsibilities of psychiatrists in the re-establishment of peace-time society."

References

[1]Group for Advancement of Psychiatry, Report on Medical Education, Report No. 3, March, 1948.
[2]Benedek, Therese, Insight and Personality Adjustment, New York, The Ronald Press, 1946.
[3]Alexander, Franz, Fundamentals of Psychoanalysis, New York, W. W. Norton & Company, 1948.
[4]Fenichel, Otto, The Psychoanalytic Theory of Neurosis, New York, W. W. Norton & Co., 1945.
[5]Alexander, Franz, and French, Thomas M., Studies in Psychosomatic Medicine, New York, The Ronald Press, 1948.
[6]French, T. M., Alexander, Franz, and others, Psychogenic Factors in Bronchial Asthma, Psychosomatic Medicine Monograph IV-part I, National Research Council, 1941.
[7]French, T. M., Alexander, Franz, and others, Psychogenic Factors in Bronchial Asthma, Part II, Psychosomatic Medicine Monograph Vol. II, Nos. I and II, National Research Council, 1941.
[8]Benedek, Therese, and Rubenstein, B. B., The Sexual Cycle in Women, Psychosomatic Medicine Monographs, Vol. III, Nos. I and II, National Research Council, 1942.
[9]Dunbar, Flanders, Mind and Body: Psychosomatic Medicine, New York, Random House, 1947.
[10]Weiss, E., and English, O. S., Psychosomatic Medicine, W. B. Saunders Co., Philadelphia & London, 1943.
[11]Levine, Maurice, Psychotherapy in Medical Practice, New York, Macmillan Company, 1943.
[12]Fromm Reichmann, Frieda, Transference problems in schizophrenincs, Psychoanalyt. Quart. 8: 412-426, Oct. 39; reprinted in Contemporary Psychopathology, S. S. Tomkins, editor, Harvard University Press, 1943.
[13]Rosen, J. N., Treatment of schizophrenia psychosis by direct analytic therapy, Psychiatric Quart. 21: 3-37, 117-119, Jan. '47.
[14]Group Advancement of Psychiatry, Public Psychiatric Hospitals, Report No. 5, April, 1948.
[15]Menninger, Wm. C., Teaching outlines of psychiatry for nurses and attendants, Bull. Menninger Clin., 8: 43-54, March, '44.
[16]Proceedings of Third Psychotherapy Council, Institute for Psychoanalysis, Chicago, 1946.
[17]Proceedings of Second Brief Psychotherapy Council, Institute for Psychoanalysis, Chicago, 1944.
[18]Alexander, Franz, French, Thomas M., and others, Psychoanalytic Therapy, New York, Ronald Press, 1946.
[19]Horsley, J. S., Narco-analysis, J. Ment. Sc., July, '36.
[20]Grinker, R. R., and Spiegel, J. P., Brief psychotherapy in war neuroses, Psychosom. Med. 6: 123-131, April, '44.
[21]Grinker, R. R., and Spiegel, J. P., Men Under Stress, Philadelphia, Blakiston, 1945.
[22]Grinker, R. R., "Treatment of war neuroses," J.A.M.A., 126: 142-145, 1944.
[23]Brenman, Margaret, and Gill, Merton M., Hypnotherapy: Survey of the Literature, Internat. Univ. Press, 1947.
[24]Thomas, Giles W., Group psychotherapy: review of recent literature, Psychosom. Med., 5: 166-180, 1943.
[25]Slavson, S. R., An Introduction to Group Therapy, Commonwealth Fund, Oxford, London, 1943.
[26]Ackerman, N. W., Dynamic patterns in group psychotherapy, Psychiatry, 7: 341-348, Nov. '44.
[27]Gesell, Arnold, First Five Years of Life, New York, Harper & Brothers, 1940.
[28]Gesell, Arnold, and Ilg, Frances, Infant and Child in the Culture of Today, New York, Harper and Brothers, 1943.
[29]Gerard, Margaret W., Treatment of young child, Am. J. Orthopsychiat. XVIII, page 414, 1948.
[30]Josselyn, Irene M., Psychosocial Development of Children, Family Service Association of America, 1948.
[31]Benedek, Therese, The Psychosomatic Implications of the Primary Unit: Mother-Child, Am.Orthopsychiat. 19: 642-654, Oct. '49.
[32]Szurek, S., Johnson, A. M., and Falstein, E., Collaborative psychiatric therapy of parent-child problems Am. J. Orthopsychiat. 12: 511-518, July, '42.
[33]Freud, Anna, Indications for Child Analysis, The Psychoanalytic study of the Child, Vol. I, 1945, New York, Internat. Univ. Press, 1946.
[34]Freud, Anna, The Psychoanalytical Treatment of Children, London, Imago Pub. Co., 1946.
[35]Pearson, Gerald H. G., Emotional Disorders of Children: A Case Book of Child Psychiatry, New York, W. W. Norton & Company, 1949.
[36]Witmer, Helen L. (editor), Psychiatric Interviews with Children, New York, Commonwealth Fund, 1946.
[37]Szurek, S. A., Notes on genesis of psychopathic personality trends, Psychiatry, 5: 1-6, Feb. '42.
[38]Levine, Maurice, Dynamic conception of psychopathic personality, Ohio State M. J. 36: 848-850, Aug. '40.
[39]Friedlander, Kate, The Psychoanalytic Approach to Juvenile Delinquency, New York, Internat. Univ. Press, 1947.
[40]Eissler, K. R., (editor), Searchlights on Delinquency, New York, Internat. Univ. Press, 1949.
[41]Halliday, James L., Psychosocial Medicine, New York, W. W. Norton & Company, 1948.
[42]Trilling, Lionel, Sex and Science: The Kinsey Report, Bull. Menninger Clin. 4: 109-118, July, '49.
[43]Mead, Margaret, Male and Female, A Study of the Sexes in a Changing World, New York, William Morrow & Company, 1949.
[44]McLean, Helen V., Psychodynamic factors in racial relations, The Ann. Am. Acad. Polit. & Social Sc., Philadelphia, 1946.
[45]Ackerman, Nathan W., and Jahoda, Marie, The dynamic basis of anti-semitic attitudes, Psychoanalyt. Quart. 2: 240-260, '48.
[46]Ackerman, Nathan W., and Jahoda, Marie, Toward a dynamic interpretation of anti-semitic attitudes, Am. J. Orthopsychiat., 18: 163, Jan. '48.
[47]Chisholm, G. B., Re-establishment of peacetime society, Psychiatry 9: 12-20, Feb. '46.
[48]Alexander, Franz, Psychosomatic Medicine, Its Principles and Applications, New York, W. W. Norton & Company, 1950.

Treatment of Peptic Ulcer

A GROUP OF WOMEN PHYSICIANS met in February, 1950, in order to determine for themselves the best management of "ulcer patients." Since one person in ten may be afflicted with this clinically prominent but etiologically obscure lesion, perhaps other physicians would like to "listen in" on this modified peptic ulcer symposium.

INTRODUCTION

Dr. Pfeiffer: The treatment of benign duodenal and gastric ulcers is usually initiated, as well as guided, by the presence of symptoms. Since brevity is necessary, most of the discussion will be directed toward the simplest management of those ulcers which have reached the stage of pain production but are otherwise uncomplicated, for example, by hemorrhage, obstruction, perforation, or persistent unresponsiveness to treatment, including surgery. Unless otherwise stated, gastric and duodenal ulcers will be considered as one entity, admitting, however, that malignancy must be excluded in all cases of stomach deformity suggesting benign ulceration.

DIET, DRUGS, AND DEACCELERATORS

Dr. Edwards: The general principles underlying medical management of peptic ulcer are (1) promotion of gastric and somatic rest, and (2) decrease of gastric secretions and hyperacidity, both measures directed toward a metabolic state which will permit and promote ulcer healing.

One accomplishes this primarily by utilizing a diet composed of non-irritating, low-residue, yet nutritious foodstuffs given in small amounts at sufficiently frequent intervals to prevent hunger contractions and hypersecretion. The average uncomplicated ulcer in the patient under 40 years is best treated by bed-rest and hourly 4 ounce feedings of a milk (3 parts) and cream (1 part) mixture to each quart of which two rounded tablespoonfuls of lactose are added to avert constipation. About two quarts of this preparation will be required in 24 hours. Ambulatory patients may carry the mixture about in a thermos bottle. It has been found that when on the hourly feeding schedule patients with uncomplicated ulcers almost always become symptom free at once, and healing progresses steadily. Those patients with an allergy to, or distaste for milk may be tried on substitutes, such as cereal gruel, gelatin, junket, or sweet-almond milk.

After about one week of the milk and cream mixture, fruit juices, cereal, jello, junket, and cream soups may be added, and, after about three weeks, cooked eggs, toast, pureed vegetables, and mashed potatoes. The hourly feedings are gradually replaced by a three-meal schedule with three between-meal feedings of milk and crackers. In about three months the patient should be able to tolerate a liberal diet which excludes tough meat and vegetable fibers, nuts, condiments, raw fruits, and those with skins or seeds, fried foods, pastries and dressings, shell-fish, smoked meats or fish, and pork products. This type of diet and the use of milk between meals should be maintained indefi-

---

This symposium is presented by members of the faculty of the Woman's Medical College of Pennsylvania. Participants are Dr. Frieda Bauman, Professor of Medicine in Charge of Nutrition and Metabolism; Dr. Mary Frances Vastine, Associate Professor of Radiology; Dr. A. Dorothea Pohlman, Clinical Assistant Professor of Neurology; Dr. Barbara Sachs, Assistant in Surgery, Woman's Hospital of Philadelphia (by invitation); Dr. Sophie A. Brenner, Assistant in Charge of Exfoliative Cytology Laboratory, Department of Oncology; Dr. Margaret H. Edwards, Fellow in Oncology assigned to Medical Clinics; Dr. Mildred C. J. Pfeiffer, Moderator, Director of the Department of Oncology; Valerie Moser, Recording Secretary.

nitely, as together they constitute the best prophylaxis against symptom relapse.

In writing down the dietary instructions for the patient, one should include measures that will help to "deaccelerate" the emotional tempo of the patient. The directions may include no more than eating slowly, avoiding very hot or cold foods, and taking a nap in the morning and afternoon and ten hours sleep at night, if the patient must be ambulatory. But the avoidance of physical activity at the onset of therapy and, in particular, avoidance of nervous tension, anxiety, and restlessness cannot be overemphasized. Almost invariably the occurrence or alleviation of an ulcer can be related to some stress-situation, if the patient is carefully questioned. The sympathetic clinician will attempt to evaluate all aspects of her patient's case and modify her plan of treatment so as to reduce rather than increase the contributory factors. Hospitalization may, therefore, serve a double purpose in removing a patient from an emotionally disturbing environment, as well as insuring full enforcement of the ulcer regime; on the other hand, the burdensome expense of hospitalization or elaborate studies in a financially insecure patient may make ambulatory care necessary. Nevertheless, every attempt should be made to help the patient to recognize his or her emotional problems, to adopt helpful philosophical attitudes, and to maintain indefinitely his or her reactions in lower gear. To this end, the understanding physician can give strong supportive therapy, if the doctor-patient relationship is sound.

Much has been written of the hyperacidity associated with peptic ulcer, and of the role of neutralization in reducing pain and discomfort and promoting healing. Milk alone is an excellent antacid, and in the majority of uncomplicated cases, dietary management is sufficient. The ideal antacid has not yet been produced.

Soluble antacids, such as sodium bicarbonate, calcium carbonate, bismuth sub-carbonate, and magnesium oxide give the most rapid neutralization and symptomatic relief, but have the disadvantages of inducing alkalosis and fostering precipitation of renal calculi. Non-absorbable antacids, such as colloidal aluminum hydroxide and phosphate, are more useful, since they do not alter the acid-base balance and are stimulants of mucous secretion. They are contraindicated in the presence of hemorrhage, in gastric stasis, and pylorospasm, because of their bulk. They are frequently employed in 4 cc. doses of the 10 percent mixture, six times daily, between meals. Magnesium trisilicate is another useful non-absorbable antacid with marked absorptive properties. It may be prescribed as 0.5 Gm. tablets, one or two being taken 15 minutes before each hourly feeding. Later, the dose may be reduced to 2 tablets between meals and before retiring, for a period of six months. Lately, non-absorbable anion-exchange resins (resinat), and detergents, such as sodium-alkyl-sulfate, have been investigated, and appear to be satisfactory antacids. Wide clinical application will be needed to interpret properly their place in ulcer therapy.

Sedatives are usually used in the early, active stage of ulcer treatment, small doses of phenobarbital, usually in liquid form, being the most satisfactory. Bromides are less irritating to the gastric mucosa and may be substituted when desired.

Antispasmodics are clinically helpful both in relaxing gastric hypertonicity by vagal depression and decreasing secretory activity of the gastric mucosa. Belladonna, atropine or related substances such as syntropan, novatropine, and trasentine, are all effective and should be used in doses sufficient to cause dryness of the mouth and dilatation of the pupils; otherwise, no physiologic effect on the stomach will be obtained. The dose should then be reduced slightly. Belladonna is often combined with elixir of phenobarbital, given every four hours during the day and a double dose on retiring. This plan may be continued for four months.

Enterogastrone, an intestinal hormone of the "chalone" type, which decreases intestinal activity, has been shown by Ivy to inhibit gastric secretion and motility when given intravenously or intramuscularly. Its oral use is still being evaluated. Seemingly it increases cellular resistance and may prove to be useful in preventing recurrences. Final evaluation continues to remain in the hands of qualified investigators.

Mucin is another substance which is being used to a limited extent; it is being studied structurally.

Medical Comments

Dr. Baumann and Dr. Pfeiffer: Most ulcer patients progressing satisfactorily will be pain-free within two to seven days, and weight gain will be further indication of improvement. If overweight should ensue, caloric readjustment, without sacrifice of the principles of regular meals of suitable quality of food and of not less frequency than four a day, must be undertaken. The daily requirements of vitamins, especially the B group and C, and of iron, can be met by individual administration, in therapeutic dosage at the beginning of treatment, and, later, on a supplementary basis. Diabetes, or other coexistent disease, such as gall-

bladder or hepatic lesions, requires extra thought. Protein hydrolysates and amino acids may be used in large amounts as ordinary food, by continuous intragastric drip, by jejunal feeding, or intravenously, with improvement in the ulcer and in the patient's symptoms.

Smoking and alcoholic drinks are mentioned with the recommendation that they be excluded from the patient's list.

Aspiration of gastric contents before retiring may be the solution to the ulcer patient's problem of persistent night pain. Continuous intragastric drip of colloidal aluminum preparations have been helpful. Milk at bed-time, or at hand if awakened at night, with or without an antacid or atropine, may tide the occasional nocturnally uncomfortable patient over to peaceful dawn.

Physical relaxation may be aided by moderate physical exercise, but strenuous sports, physically or emotionally, are interdicted.

Even though the patient's symptoms may subside, healing of the ulcer may not take place for some time. Gastric ulcers should be re-x-rayed in two to three weeks for signs of healing. If there is any doubt, the surgeon should be consulted. Duodenal ulcers might be rechecked in four to eight weeks.

Many ulcers heal completely. Others subside temporarily, but fail to heal completely and may eventually require surgery. The ulcer patient needs long-term observation and advice.

The Place of Roentgen Therapy in the Management of Peptic Ulcer

Dr. Vastine: Irradiation is not generally employed in the treatment of peptic ulcer. A few investigators have made use of this form of therapy in an attempt to inhibit the acid-producing cells of the stomach. Workers at the University of Chicago have reported results from roentgen irradiation of the fundus and corpus of the stomach in some 800 cases. They conclude that this therapy depresses the secretion of gastric juice, which is necessary for the maintenance of peptic ulceration. The fundal portion of the stomach was irradiated from two portals, one anterior and one posterior. Dosage to the fundus varied from 666 to 2,500 r, this amount being delivered in from 6 to 14 days. Roentgen therapy of the acid-secreting portion of the stomach proved valuable because the gastric secretion was reduced. No correlation between effects of treatment and age of the patient or duration of the disease before irradiation could be made. A higher incidence of postradiation achlorhydria was noted in the patients with gastric ulcer than in those with duodenal or jejunal ulcer. The achlorhydria induced by this means persisted from a few days to eight years. Ulcer pain disappeared during achlorhydria and radiation achlorhydria did not, in itself, produce symptoms. The absence of acid gastric secretion for three months invariably resulted in healing of the ulcer, while reappearance of acid in the gastric secretion heralded recurrence of the ulcer. However, the incidence of recurrence was lowered by irradiation.

One investigator gives treatment over the stomach in the peptic ulcer patient in an attempt to straighten out the upset nervous mechanism. The rationale underlying this therapy consists in the belief that there is a disturbance in the vegetative nervous system in the ulcer patient. Normally, the vegetative nervous system is highly radioresistant; but in the ulcer patient the nervous mechanism is generally or locally in a state of increased sensitivity. One part of the system, probably the sympathetic, is predominantly involved, and this increased sensitivity permits reaction to x-rays on the part of the involved nerve cells. It is believed that the radio-sensitivity of a tissue depends on the metabolic state prevailing at the time of the irradiation. In general, small doses (90 to 100 r at the surface) are given to a 10 by 15 anterior epigastric field. Six treatments are given in 14 days, and after a 14-day interval the dosage is repeated or given to the corresponding posterior field.

From this discussion on the role of irradiation in the treatment of peptic ulcer in two clinics, the one in this country and the other in Europe, it would seem that such therapy could with impunity be more widely employed. The theories underlying use of roentgen therapy may differ slightly; but except for minor variations the dosage and methods of administration are much the same.

Discussion by the Neuropsychiatrist and the Surgeon will be published in the August JOURNAL.

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

EDITORIAL SECTION

WORLD HEALTH ORGANIZATION

FOUR YEARS AGO, on July 22, 1946, the constitution for a World Health Organization was signed by representatives of sixty-one governments assembled in New York for the International Health Conference. Plans were laid down for establishment of an international health body covering all aspects of health. It was recognized that health whether for nations or for individuals required teamwork between governments and peoples on a scale vastly greater than ever before in history.

The WHO constitution was unanimously adopted and this document, a declaration of the rights of man to freedom from sickness, has come to be known as the "Magna Carta of Health." The concepts of its duties as an international health institute are well stated in the preamble to the constitution.

Now seventy-four states are members of WHO, thus making it the largest of the specialized agencies of United Nations. This increase in membership reflects the growing realization of governments that control of disease and promotion of health require the united action of all nations. Disease and pestilence ignore politically established boundaries. The world is rapidly shrinking —no point on the globe is more than a few days distant. Modern methods of transportation have stimulated more movement of people between countries and continents. They have also outmoded older methods of quarantine. Today, therefore, control of communicable disease must be carried out on a global scale. Nations are beginning to recognize their fundamental interdependence in the field of health.

The achievements of the World Health Organization in this, its first full year of operation, demonstrate that nations of different languages, different ideologies, and different customs can work together efficiently and amicably. The report of the Director-General (page 280) is a testimonial to the effectiveness of international cooperation by which many millions throughout the world now are experiencing the benefits of improved personal and public health. But these same people, whether in a little hamlet or in a large metropolis, must also be experiencing a significant spiritual uplift from the knowledge that their improved condition has been achieved by teams of men and women of different color, different tongues, working together toward the solution of their health problems.

We are proud that the JOURNAL can participate in the dissemination of information regarding WHO, and in this, our annual International Number, we present a brief account of WHO activities for the past year. Surely this wonderful record of achievement calls for greater encouragement from all citizens of the world and for increased financial and material support from all governments. For health—"the attainment by all peoples of the highest possible level of health"—may be the foundation upon which we will build the One World. —A.C.R.

PREAMBLE TO THE CONSTITUTION OF THE WORLD HEALTH ORGANIZATION

"The States parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all people:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

"The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

"The achievement of any State in the promotion and protection of health is of value to all.

"Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

"Healthy development of the child is of basic importance: the ability to live harmoniously in a changing total environment is essential to such development.

"The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

"Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

"Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

THIRD WORLD HEALTH ASSEMBLY

The Third World Health Assembly opened May 8, 1950, in the Assembly Hall of the Palais des Nations, Geneva, in the presence of important delegations from nearly all the 69 member countries; (during the Assembly, Cuba, Republic of Indonesia, Viet Nam, Camboda, and Laos became full members, bringing the total to 74 states plus one associate member). Thus WHO is the largest of the specialized agencies of the United Nations even though eight members have notified WHO of their withdrawal.

At the opening ceremonies, Mr. Trygve Lie, Secretary-General of United Nations, called upon governments to put an end to the "cold war" and help United Nations and its specialized agencies to create conditions of economic and social security which could serve as a basis for durable peace. The annual report of the WHO Director-General, Dr. Brock Chisholm, was presented, in which was noted a marked increase in WHO services to governments in 1949; assistance to 79 countries and territories was reviewed in the report (page 280).

The Rajkumari Amrit Kaur, Minister of Health for India, was unanimously elected President of the Assembly. In the opening remarks of her address she stated, " . . . I have loved WHO because I have faith that, if all the nations of the earth hang together and work with a will, nothing but success can crown our joint endeavours. For our cause is righteous and it shall prevail . . . Though we live in different countries, speak different languages, and belong to different races, the language of the heart is one and human nature is the same the world over. That kinship must be made to rise above all the barriers that today divide us, one from the other. There is room in the world for all of us. All seek the same end, the happiness of mankind, and there can be no happiness, no progress whether economic, social, moral, or spiritual, if the health of the peoples continues at a low level. On those who have been called to the noblest of all professions, the art of healing, lies a special responsibility. They are in charge not only of physical but also of mental health—if confidence is to replace fear it can only be done through love and service."

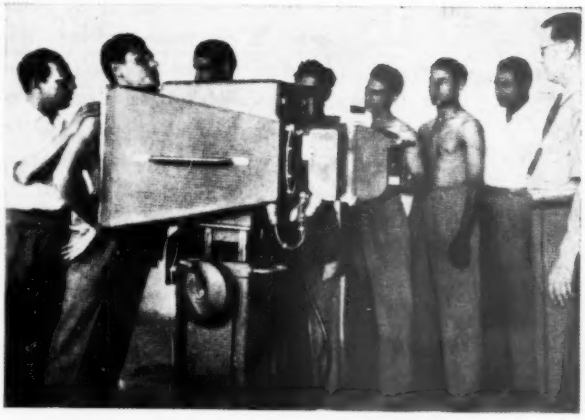
RAJKUMARI AMRIT KAUR
President
Third World Health Assembly

There followed three weeks of intensive work: A four-year plan for world health, approval of a number of research programs, development of technical and operational sources, decentralization of relief work, and consideration of next year's program and budget were among the 70-odd item agenda. The Assembly came to an end on May 27 with a farewell speech by its President, the Rajkumari Amrit Kaur. In closing, she spoke of the "heart rending task" the Assembly had faced in having to cut out "obviously necessary programs" because of lack of funds. The President declared that delegates to the Assembly should return home with the intention of making WHO better known so it would become "the people's concern." For, "It is on people's pennies rather than on governmental donations that we will thrive."

WHO Around the World

DURING THE PAST YEAR, WHO has carried out surveys in or has given assistance to 79 countries and territories in all parts of the world. The report of the Director-General presented at the third World Health Assembly described campaigns against communicable diseases, with stress on malaria, tuberculosis, and venereal diseases; activities designed to improve physical, mental, and social well-being (maternal and child health, mental health, and nutrition); aid to governments in organization of public health services, including improvements in sanitation, health education of the public, and nursing services; and efforts to extend professional and technical education through organization of training courses, granting of fellowships, and provision of medical supplies and literature.

The report presented a country-by-country review of action taken by WHO-assisted governments in six regions—the Eastern Mediterranean, the Western Pacific, Southeast Asia, Europe, Africa, and the Americas. Some of the major projects in those areas follow:



Tuberculosis survey in Egypt—Mass radiography examination.

Eastern Mediterranean Region

WHO assisted the International Tuberculosis Campaign to carry out mass vaccination against tuberculosis among Arab refugees from Palestine in surrounding Arab countries. A thorough investigation of the spread of bejel was carried out in Syria, the Hashemite Kingdom of the Jordan, Lebanon, and Iraq.

An anti-malaria campaign was carried out among Arab refugees from Palestine resulting in the suppression of transmission among them. This was followed by campaigns against flies, fleas, and lice.

In *Aden, Cyprus,* and *Saudi Arabia,* tuberculosis problems were surveyed by WHO.

Egypt also received aid in a tuberculosis survey, in a mass x-ray program, and in setting up of training centers for tuberculosis control personnel. A WHO consultant surveyed venereal disease problems; a venereal disease control demonstration team was appointed; and supplies, including penicillin, were procured. A sanitary officer studied the problem of schistosomiasis, a parasitic disease widespread in Egypt.

In *Ethiopia,* WHO stressed training of local health personnel. On July 1 the first school for nurses was opened in Addis Ababa, with teaching material and nurses' uniforms contributed by WHO. First aid and sanitation courses were also given.

In *Jordan,* bejel and venereal disease problems were studied, and a survey of tuberculosis was completed.

Following a malaria survey in *Iran,* WHO experts conducted a small demonstration of control techniques. More extensive work is now under way.

For *Iraq,* WHO arranged procurement of penicillin for venereal disease control and surveyed tuberculosis problems.

In *Israel,* a WHO representative conferred with public health officials of major cities on integration of existing health agencies into a national health organization, termed by the report "one of the most urgent problems in the country."

In *Lebanon,* WHO representatives surveyed tuberculosis, investigated laboratory facilities for the proposed bejel control project, and conferred on public health problems.

[All photographs reproduced on these pages are official United Nations photographs obtained from the WHO Department of Public Information.]

To help *Pakistan* in malaria control, WHO, assisted by the United Nations Children's Fund, established a demonstration team in East Pakistan. Venereal disease services and other public health problems of the country were also studied.

At *Syria's* request, a WHO consultant made a preliminary survey of bejel. An expert on maternal and child care visited the country, and tuberculosis was surveyed.

To aid *Turkey* in malaria control, WHO sent a sanitary engineer to advise on techniques and supplied insecticides for demonstrations. Tuberculosis problems were studied, and penicillin was provided for venereal disease control.

Western Pacific

In *China,* although WHO "activities were somewhat curtailed" because of the spread of the civil war, "field work was carried on in various areas without political discrimination." Aid was given in the teaching of tuberculosis nursing in four cities; in Shanghai a WHO nurse supervised a mass x-ray examination of some 5,000 Chinese children; a surgeon assigned to a hospital in Canton conducted training courses. "Another WHO consulting surgeon remained in Northern China throughout the year" and organized training of local health personnel. Aid was given in control of plague and other diseases and in an audio-visual health education project conducted in Szechuan Province by the United Nations Educational, Scientific, and Cultural Organization.

In conjunction with the UN Children's Fund WHO consultants planned yaws control in *Indonesia;* arranged for training of nurses and child-welfare programs in *Malaya, North Borneo, Brunei,* and *Sarawak;* and aided in maternal and child health projects in the *Philippines,* where WHO also advised on national sanitation programs and assisted in planning yaws control.

A maternal and child health team was sent to *Korea* to establish a children's center in Seoul with UNICEF help.

Southeast Asia

In *Afghanistan,* WHO experts surveyed malaria problems and conducted a pilot demonstration project, surveyed venereal disease problems, investigated needs in the field of maternal and child care, and helped to control an outbreak of louse-borne typhus. In addition, methods of preventing the usual seasonal increase of typhus were demonstrated.

School children in Thailand are examined by Thai nurses, working under WHO Public Health supervision.

An anti-venereal disease campaign in *Burma* was organized with UNICEF aid.

In *Ceylon,* WHO representatives studied filariasis, surveyed tuberculosis services, held a seminar on venereal disease control, and arranged for a study of widespread goiter problems.

In *India,* malaria demonstration projects were begun at Terai in the United Provinces, in the Jeypore Hills in Orissa, at Malnad in Mysore, and at Ernad in the Malabar District. The WHO teams, with supplies from UNICEF, demonstrated DDT control, aided in general health programs, and gave emergency aid in disease outbreaks. WHO also established a venereal disease demonstration project in Simla, aided in tuberculosis control, assigned a reconnaissance team to study maternal and child health problems, and gave emergency aid in control of poliomyelitis.

Another malaria team was assigned to *Thailand,* where WHO is planning aid in 1950 in campaigns against tuberculosis and yaws.

Maternal and Child Health in India. WHO Pediatrics nurse in Indian village.

Europe

"The largest single project" in Europe was assistance in a survey of *Italy's* health services, conducted by the Italian Government, the Rockefeller Foundation, and by WHO, the report states. WHO provided experts in malaria, tuberculosis, venereal disease, maternal and child health, sanitation, industrial health, public health statistics, laboratory services, and port and airport sanitation.

Special attention was given to advanced training oportunities, and arrangements were made in 1949 for aid in such projects as a state medical library set up by the Government of Czechoslovakia, centers for anesthetists at Prague and Copenhagen, and training centers in biochemistry and venereal disease control in Poland.

Twenty-seven governments in Europe, including *Albania,* received some type of assistance, literature, and fellowships: *Austria,* aid in the fields of venereal disease, mental health, and tuberculosis statistics; *Bulgaria,* help in an anti-syphilis campaign; *Byelorussian SSR,* supplies of books and periodicals; *Finland,* advice in venereal disease control and supplies of literature; *Germany,* survey of venereal disease treatment facilities along the Rhine River; *Hungary,* aid in malaria control, a survey of tuberculosis, assistance in a national anti-syphilis campaign; *Ireland,* investigation of health needs and facilities; *Italy,* aid in malaria, venereal disease and nutrition programs, and a survey of tuberculosis; *Luxembourg,* investigation of needs and facilities for health programs; *Monaco,* consultation on needs for medical literature and teaching equipment.

Portugal, consultations on tuberculosis programs; *Rumania,* advice in anti-syphilis and malaria control programs; *Switzerland,* advice in planning of a seminar on social pediatrics; *Ukrainian SSR,* supplies of literature; *United Kingdom,* advice regarding a large-scale whooping cough immunization campaign.

For *Belgium,* arrangements were made to send penicillin to Liege for demonstration of syphilis treatment. WHO representatives completed a tuberculosis survey and advised on maternal and child health.

As part of a venereal disease control campaign in *Czechoslovakia,* a WHO expert lectured throughout the country; penicillin and laboratory equipment were supplied. Aid in training courses was arranged for 1950.

A model treatment scheme for venereal diseases was established in *Denmark* at the Copenhagen University clinic. Teaching equipment was provided for a training center for anesthetists.

A maternal and child health expert visited *France* and studied poliomyelitis and premature-baby care. Penicillin was obtained for demonstrations of venereal disease treatment in several cities of France.

A case of tuberculosis meningitis is treated with streptomycin at the St. Sophia's Children's Hospital in Athens.

In *Greece,* malaria and tuberculosis control, in which WHO had aided in previous years, progressed. WHO consultants on streptomycin treatment visited the country, and aid was given in setting up tuberculosis laboratories in Athens and Salonika.

In *Iceland,* WHO and UNICEF have undertaken scientific study of the tuberculin test. The country, because of its location, "offers an exceptional opportunity for such studies," the report states.

Aid was given the *Netherlands* in a survey of venereal disease treatment centers along the Rhine, a tuberculosis survey, demonstrations of penicillin treatment of syphilis, and health education of the public. Similar treatment projects were arranged in *Norway* and *Sweden.*

In *Poland,* WHO representatives demonstrated x-ray technology, advised streptomycin workers using supplies from UNICEF, aided in veneral disease control, and supplied color film as well as literature for scientific purposes.

Yugoslavia received aid in a malaria control program, venereal disease problems, and a campaign against tuberculosis. WHO experts advised on use of streptomycin and x-ray equipment provided by UNICEF.

School children in Yugoslavia are examined in anti-malaria campaign.

Africa

Lists of films in French, for use in teaching medical subjects, were supplied to the *Belgian Congo;* aid was offered to *Liberia* in health work, following a preliminary request; aid was given to the *Union of South Africa* following outbreaks of smallpox.

Americas

WHO experts surveyed tuberculosis problems in *Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Panama, Paraguay, Peru, Puerto Rico, Uruguay,* and *Venezuela.*

By the end of 1949 special programs had been planned in conjunction with UNICEF for control of yaws and rural syphilis in *Haiti* and the *Dominican Republic;* insect control in Central America *(British Honduras, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua);* immunization against diphtheria and whooping cough in *Chile* and *Colombia;* typhus control in *Bolivia* and *Peru;* and, with the Food and Agriculture Organization, a nutrition program in *Costa Rica, El Salvador, Guatemala, Honduras,* and *Nicaragua.*

In addition, special assistance was give to *Ecuador* following the earthquake in the summer of 1949.

WHO supplied a public health officer and nurse for the pilot project in fundamental education being conducted by *Haiti* and the UN Educational, Scientific, and Cultural Organization.

A WHO consultant on malaria visited *Mexico,* and a venereal disease expert advised on problems along the border of Mexico and the United States. Aid was given in establishment of a laboratory in Mexico City for production of BCG anti-tuberculosis vaccine.

At the request of the *United States,* WHO representatives advised on Vitamin B_{12} and anemia, malaria, and sanitation problems.

In *Venezuela,* WHO made a tuberculosis survey. A WHO venereal disease consultant examined a venereal disease control program and gave advice on future needs. An expert serologist was appointed to head a serological laboratory and training center, to start in 1950. The WHO expert on health statistics gave a series of lectures at the Central University of Caracas. Medical literature and teaching equipment were supplied and WHO considered requests for consultants in psychiatric nursing and psychiatric social work in 1950.

The International Tuberculosis Campaign

Esther Ammundsen, M.D.

DURING THE PAST TWO YEARS, a program for control of tuberculosis has been carried out under the above name, having as its original aim the tuberculin testing and BCG vaccination of children and young people in war-ravaged countries in Europe. As time has elapsed, the work has developed to include countries outside Europe, and to-day programs have been and are being carried out in seventeen countries (Finland, Poland, Hungary, Yugoslavia, Czechoslovakia, Austria, Germany, Italy, Lebanon, Egypt, Morocco, Tunisia, Algeria, Israel, India, Pakistan, and Ceylon). Work will commence shortly in Syria, Malta, Mexico, and Ecuador.

The organization was established when the United Nations International Children's Emergency Fund and some of the relief organizations in Scandinavia combined forces and set up headquarters in Copenhagen. Countries that were desirous of having BCG vaccination campaigns and were eligible under the conditions laid down for benefit from such campaigns entered into contracts with the central administration, the leader of which is Dr. Johannes Holm, Chief of the Tuberculosis Division, State Serum Institute, Copenhagen. Thereafter, mass vaccination campaigns are planned, using partially national and partially Scandinavian personnel.

One of the reasons why this task has been undertaken by the Scandinavian countries is that BCG vaccination has been used very widely for many years in Scandinavia to protect the population against tuberculosis, thus acquainting quite a large number of doctors and nurses with the organization and the technique of the vaccination.

After the organization has operated in a country for varying periods, dependent on the size and construction of the country, and after a total campaign has been carried out as far as possible (i.e. when all persons in the 1-18 age-groups have been offered tuberculin testing and vaccination), the Scandinavian personnel withdraw, leaving behind them sufficient equipment — tuberculin, syringes, needles, cars, etc.—to enable a continued program and a later follow-up of the vaccinated persons. At the same time, assistance is offered with establishment of BCG laboratories, so that the countries themselves can prepare their own BCG vaccine.

Dr. Ammundsen is Medical Director in Charge of Personnel of the Danish Red Cross-International Tuberculosis Campaign, with headquarters in Copenhagen.

In countries outside Europe, it has been impossible, of course, to carry out vaccination of the whole population, because of the vastness of the countries and the lack of organization. Here action has taken the form of demonstrations, during which selected groups have been tuberculin tested and vaccinated, and emphasis has been placed on the training of as many and as efficient local personnel as possible for continuation of the work.

The technique used to date has been generally as follows: A single tuberculin test—the so-called Moro Plaster test—has been used for children under 12 years of age. Mantoux with 1 T.U. has been used as the first and Mantoux with 1o T.U. as the second test for persons over 12 years of age. All non-reactors to tuberculin who have not expressed definite objection have been vaccinated.

As the work has developed, it has become evident that the technique normally used in Denmark must be adjusted somewhat for use in countries with other races, other climates, and less enlightenment. The Moro Plaster test does not seem to be suitable for dark-skinned races, and the early occurrence of puberty in young persons in many countries means that this test can be used only in the lower age-groups.

It is impracticable in many places to use two tuberculin tests, and therefore efforts have been made in various countries to use either Mantoux test with 5 T.U. as the only test, or a modified form of Pirquet test as used in Norway, with the addition of 1 percent adrenalin. The experience gained has not yet been statistically and scientifically compiled, so that it is not possible to state anything definite concerning tuberculin technique or the ability of the vaccine to cause allergy, still less concerning its long-term protective value under

primitive conditions. In order to investigate these problems, the World Health Organization has established a research office in Copenhagen, under the leadership of Dr. Carroll Palmer, for the purpose both of analyzing the statistical material collected during routine work, and of sending out special teams to obtain information regarding the different problems which arise.

The organization has now concluded its work in several European countries—Poland, Czechoslovakia, Hungary, and Finland—and during the course of 1950 will have completed its task in Europe, whereafter continuation of the work will be the responsibility of the individual countries.

The action in distant countries has encountered many difficulties and its final form has not yet been established definitely. Experiments are now necessary before it can be decided in which form BCG vaccination can be carried out most effictively in large countries—such as India. Here assistance is needed from other international organizations, and it is contemplated combining BCG vaccination stations with the centers which WHO is planning to establish in so-called "under-developed" countries for the prevention of tuberculosis.

During the whole campaign, a total of 18,212,502 persons have been tuberculin tested and 8,481,490 have been vaccinated from the summer of 1947 until November 30, 1949. Funds for the work have come from UNICEF and the Scandinavian voluntary organizations, and a sum of almost three million dollars has been used up to the present.

It is realized by everyone working in this campaign that BCG vaccination is only one of the weapons with which tuberculosis can be combated, but, since we are convinced of its protective value, we have considered it our duty to assist with this preliminary measure in countries where lack of enlightenment and poor social conditions make the tuberculosis problem almost unsolvable, in the hope that the countries themselves will be enabled to establish complete tuberculosis control programs.

International Cancer Meetings

Perihan Cambel, M.D.

In 1933 the First International Cancer Congress was held in Madrid, Spain. At that meeting a resolution was passed creating the *Union International contre le Cancer,* with headquarters in Paris, which from then on was to sponsor all international cancer research meetings (Article 1). It was decided also that this union should be a federation of all national organizations, associations, and institutions involved in the scientific and social campaign against cancer (Article 2).

Forty-four nations were represented at the Second International Congress, held in 1936, in Brussels, Belgium. The Third Congress met in 1939, in Atlantic City, New Jersey. Because of the interruption of World War II, there was a lapse of eight years before the Fourth International Congress met in St. Louis, Missouri, in 1947, the meeting being arranged mainly through the cosponsorship of the American Association for Cancer Research. Through the generosity of American foundations, the European attendance was large. Among the national representatives were two women: Dr. Elise S. L'Esperance for the United States, and Dr. Perihan Cambel for Turkey.

Dr. E. V. Cowdry, Vice-President of the Congress, prompted the formation of the Executive Committee of National Representatives. Forty governmental or national delegates, each representing one of the nations attending, met every day during the Congress, under his leadership.

The nations thus represented became charter members of the future International Cancer Research Commission, the creation of which was suggested to the Congress, among other recom-

Dr. Cambel, now in the United States on leave of absence from the Turkish Ministry of Health, is working as Associate Professor at the Cancer Research Laboratory, University of Florida, Gainesville, Florida.

mendations. As a former member of the Executive Committee of National Representatives, in 1947, and because of my faith in the International Cancer Research Commission, I take a keen interest in the fate of this organization and wish to report on it to the readers of the JOURNAL of the American Medical Women's Association.

The first meeting of the International Cancer Research Commission was held in Paris, July 18 to 22, 1949, under the chairmanship of Dr. Ignacio Millan (Mexico). Paris was recommended as the site for the Fifth International Cancer Congress, to be held July 17 to 22, 1950, and Dr. A. Lacassagne, the eminent French cancerologist, was named as President of the Congress.

Dr. J. Maisin (Belgium) reported that the Union, and consequently the Commission, as part of the Union, had been incorporated into both the World Health Organization and the International Council for the Coordination of International Congresses in Medical Sciences (a UNESCO and WHO subsidiary). A grant from UNESCO financed the publication of the Transactions of the Fourth Congress. These transactions are now nearly completed and are appearing in six parts (about 2,000 pages) in *Acta*, organ of the Union.

Dr. Cowdry (United States) called attention to the progress made in expanding the Commission by the addition of 11 new member nations to the 40 charter members, making a total of 51. The goal set for 1950 is all nations.

The national representatives presented reports on advances in cancer research in their respective countries. Mimeographed summaries of expenditures by the American Cancer Society and other organizations, prepared by Mr. J. H. Teeter; the Cancer Bulletins of Texas and Michigan; and Dr. Ralph Meader's report, representing the United States Public Health Service and the American Cancer Society, on Governmental financing of cancer research, all awakened general interest. Dr. W. U. Gardner (additional representative of the United States and alternate member of the Executive Committee) spoke on the publication of cancer atlases and reviews of cancer literature, a service repeatedly urged by the national representatives. It was unanimously agreed that such annual progress reports are of great value and that more time should be devoted to their discussion.

The following statement was adopted by the Commission: "The duties of the International Cancer Research Commission are to advance research in cancer (1) by serving as the *Conseil scientifique* of the Union; (2) by pooling information at annual meetings and on specific topics at special small meetings; (3) by obtaining more agreement on cancer nomenclature through the publication of atlases and through other means; (4) by giving advice on the planning of cancer research, when asked; (5) by helping to secure equipment and supplies, when asked; (6) by promoting studies on the environmental (occupational and geographic) pathology of cancer; (7) by facilitating adequate review of the cancer literature."

Committees were appointed for review of cancer literature, for furthering agreement on cancer nomenclature by the publication of atlases, and for the geographic pathology of cancer. It was decided that Dr. Meader should supply Dr. Millan with copies of a suitable questionnaire to be forwarded to all members of the Committee with the request that they be returned directly to Dr. Meader, to expand his registry of cancer research institutions, equipment, and workers.

The duties of the Committee as outlined above were approved and included in the charter of the Commission with the principles adopted by the Fourth International Cancer Congress.

The next meeting of the Commission will be held in Paris, starting on July 15, 1950.

* * *

The Pontifical Academy of Sciences met in Rome on June 6 to 13, 1949. It was attended by 14 representatives from Belgium, England, France, Italy, Scotland, Spain, Sweden, Switzerland, and the United States, The Holy Father having called a few scientists together, without regard to race, creed, or any other distinction, to discuss the problems of cancer. All expenses of the participants and of their spouses while in Rome were generously paid by the Vatican. The meeting was well organized through the efforts of the well-known cancerologist, Dr. F. Rondoni, a member of the Pontifical Academy. The United States was represented by Dr. E. V. Cowdry (Washington University, St. Louis) and Dr. Jesse P. Greenstein (National Cancer Institute). There was no woman delegate. The Holy Father gave specific instructions that the representatives should (1) reach a decision as to the area of agreement in the cancer problem; (2) define the principal areas of disagreement; and (3) recommend the best means to overcome the disagreements.

The final report, delivered after ample discussions, will be published from the Vatican.

Medical Women and Group Practice

As Seen by a Canadian

Agnes K. Moffatt, M.D.C.M.

THE TOPIC OF THIS ARTICLE has been chosen for several reasons: to illustrate the trend today of unsocialized medicine in Canada, to point out some of the advantages of such a trend, and to show the part a medical woman plays in this type of practice.

Most of my conclusions are drawn from thirteen years of personal experience as a full-time member of The Peterborough Clinic. This clinic was the first of its kind to be established in Ontario, and one of the first in Canada, the year being 1920. Since the inception of this clinic it has shown steady progress and has gained and held the respect of both lay and professional groups. At the outset the medical university centres were somewhat critical of any type of clinic formation because it represented a new departure in organization; it brought to the surface a new economic feature which they had not realized. Some considered such organized group practices almost unethical. However, in spite of some hostility, particularly in the earlier years, our clinic has acted as a stimulus for the formation of other group practices and clinics just as the success of the Mayo Clinic encouraged our six charter members to embark on a smaller but similar venture thirty years ago.

The majority of group practices in Canada have been established in the smaller, non-teaching, non-university centres, although some larger university centres, Winnipeg, Edmonton, and Vancouver, have developed excellent clinics in spite of considerable early antagonism from the teaching centres. The success of these groups is evidenced by: (1) the greater number of people being served by the organized groups, and the regard and respect which patients show for the type of treatment received at or through these centres; (2) the increasing appeal of this type of practice to well-trained and qualified physicians and surgeons; (3) the change in attitude of medical leaders toward this mode of practicing. (Professors in our best medical colleges who at one time looked askance at group practice have had to change their minds, and some have even admitted that, if they were now starting up in practice, organized group practice would be their choice.); (4) the change in attitude of other practicing medicos in the same city as established clinics. (At first their attitude was often hostile and antagonistic. Now they have either formed groups of their own or have accepted the fact that they are in the minority).

Dr. Moffat is Pediatrician and Anesthetist, the Peterborough Clinic, Peterborough, Ontario, Canada.

Army medical life in the last war did much to foster the idea of working in groups and we find many ex-servicemen and women more anxious to become affiliated with such groups. The Army organization and cooperation, with "time off" for holidays and study made many doctors feel that the same organization could be applied to the practice of medicine in civilian life.

Medicine is becoming more and more a science and this science is opening up so many new fields that a generally trained physician is unable to cope with all the angles and intricacies of specialties. Each specialty in itself requires the aid of other specialists as well as the aid of trained technicians and nurses. The internist requires the pathological chemist, the hematologist, the bacteriologist, and the technician for basal metabolic rates and electrocardiograms, etc.; the surgeon requires the pathologist, the radiologist, the radio- and physio-therapist, etc. Neither one, alone, can financially support these requisites of modern practice. In a group, such facilities can be afforded and used by all, a definite advantage to the patient as well as to the doctor.

At this stage, a definition of "group practice" should be given. Group practice refers to a group of doctors practising together and sharing all or some of the following: (1) laboratory facilities, i.e., x-ray, pathological chemistry, hematology, bacteriology, etc.; (2) surgeries; (3) nursing staff; (4) physiotherapy; (5) pharmacy; (6) clerical help and business management; (7) library; (8) housekeeping and janitor service. The group may consist of (1) all general practitioners; (2) all specialists; (3) some specialists and some general practitioners. The group may be organized as (1) a partnership; (2) a limited company; (3) a combination of partnership and limited company; (4) a foundation; (5) a non-profit company; (6) a "one-man clinic" with salaried conferees.

Let us consider the advantages of organized

group medicine: (1) for the doctor; (2) for the woman doctor; (3) for the married woman doctor; (4) for the unmarried woman doctor; (5) for the patient.

(1) The individual doctor shares in many ways and many times a day the privileges, facilities, work, and companionship provided by the group. Consultations can be given and received easily and expeditiously for all involved. Most laboratory reports are available before the patient leaves the office. Procedures such as lumbar punctures, nerve blocks, pneumothoraces, paracenteses, manipulations, electrocardiograms, injections, and intravenous therapy are very little trouble with sterile equipment always available and nurses and anaesthetists at hand. Basal metabolic rates, physio- and radio-therapy treatments and x-ray investigations can be readily arranged and supervised in an organized group with ample equipment. Many fractures can be reduced under the fluoroscope with the aid of pentothal, a plaster applied, and the patient on his way home inside of an hour. Many hours and dollars of hospitalization may be saved the patient by this service and at the same time much energy on the part of the physician and surgeon. New diabetic patients can receive instruction from qualified nurses and laboratory technicians, thus avoiding hospitalization. Special prescriptions can be filled quickly in a specially equipped pharmacy. The doctors' medical bags are packed with the necessary drugs from the dispensary and to them are added all the sterilized syringes, needles, gloves, towels, and instruments each member requires. The office clerks attend to all the accounts and business correspondence. The accountant prepares income tax forms so that all that is required are the doctors' signatures. Fees to special organizations, societies, and publications are attended to without the doctor having to give them a thought. The files and medical library are cared for by another secretarial helper. Medical equipment and supplies are handled by the head nurse and business manager so that the doctor's mind is freed of all trivial but necessary details of practice. Vacations, postgraduate courses, and conventions are usually arranged well in advance, and travelling expenses and salaries generally go on during these legitimate absences from practice. Reports of conventions and postgraduate courses are usually made afterwards to the rest of the group and often some form of educational program is arranged yearly to include not only group members but also professional confreres outside.

(2) A woman doctor who decides on this type of practice will be very happy for she shares in the advantages common to the man as just mentioned, and has additional benefits as well: (a) She has been publicly accepted by a recognized and respected group of professional men in the community and this immediately puts her on an equal status—medical women are still considerably in the minority, especially in the smaller cities and towns. Lonely years of proving one's worth to the community are avoided by becoming associated with such groups. (b) She has male companionship which is necessary to keep a woman's perspective true. Most of her patients will be women or children, regardless of where she practices, so that the constant contact with the male outlook is invaluable. (c) From the older and more experienced members of this closely-knit group she will learn much about life and the practice of medicine, advice and information not found in textbooks. The "one-big-happy-family" feeling which some of these groups possess is priceless because in it one has the opportunity of unburdening one's worries and of receiving sound advice from friendly, understanding, experienced, clear-thinking elders.

(3) A married woman doctor will find this type of practice ideal, for, added to the above-mentioned advantages, she will find that (a) holidays and "time off" with husband and children can be arranged more readily, since usually in such groups vacation schedules are set up well in advance. She knows her practice will be well-looked after by friendly confreres during her absence, and as a result she will be able to relax completely and give wholehearted attention to her family. (b) Should pregnancy occur, her condition will be accepted by the members of her group as a physiological, not a pathological state, and she will be encouraged to carry on with her work throughout most of her pregnancy. Child bearing can help rather than hurt her practice if she sees that she has adequate domestic help and organization. Pregnancy and motherhood give the woman physician an understanding which no male physician could ever acquire. The smaller city is definitely the ideal setting for combining family and practice. The mother is within call of the home at all times, maybe five to fifteen minutes away. She is not often deprived of lunch at home with the family. Then, too, the members of this friendly group are always ready to step in and help with sickness in her family if she is away on holidays or doing postgraduate work or attending conventions.

(4) Most of the advantages of group practice for the unmarried woman have been stated above,

but emphasis must be laid on the importance of the male companionship and mental and social intercourse derived from such a mixed group. Women have not been accepted as physicians and surgeons wholeheartedly by all Canadians yet, and any step a medical woman can make that will bring her sex more in favor with the public, the sooner medical women will be recognized universally.

(5) Much has been said of the advantages to the physician of practicing in a group, but what of the patient, who is after all, our chief concern? The patient has much to gain: (a) A thorough examination, and maybe consultations by competent physicians and surgeons with up-to-date methods of investigation, at a minimum cost, within a minimum time, and with a minimal amount of discomfort. (b) The security of always being able to get a doctor, day or night, Sundays or holidays, who, if not the "regular" doctor, is associated with him or her and is similarly qualified and specialized, who has recourse to the patient's files, and who will report to his or her doctor when he or she returns. (c) The problem many people have nowadays is to know which doctor to call for a particular complaint. The knowledge that one organized group can deal with anything well, in spite of no previous personal contacts, is a comfort to many patients. The clinic or group automatically steers the patient along the proper channels to the required type of specialist for his or her case.

But the association of the woman doctor with this group is not always one of receiving, for she may be of considerable assistance to the organization. (1) Many shy and retiring female patients have received timely treatment and help because they were not too timid to approach a "woman" doctor about their complaints. As a woman, this doctor can carefully and wisely channel these patients to the appropriate specialists if she has not the qualifications to see the case through herself. (2) She may help relations with the female nurses and technicians. (3) Her relations with other women's organizations in the city or town may help bring the group in even more favor with the public. (4) She may assist in the social life of the group as hostess to visitors, etc. (5) She may be of some assistance in the planning and decorating of offices and waiting rooms, by providing the womanly touch.

May I indulge in a few personal remarks and give testimony to the pleasure and satisfaction of group practice as I have experienced it for the past thirteen years. The six men who founded this clinic thirty years ago were men of unusual integrity and character, each one with a firmly established practice and some degree of specialization at that time. By the availability of postgraduate study and the referring of cases within the group, their individual specialties became strengthened. Not only did the men become well specialized but they demonstrated at all times a keen and broad interest in the trend and progress of medicine in this province and in Canada. This is illustrated by the fact that two members were Presidents of the Ontario Medical Association. One, in fact, reorganized our Ontario Medical Association and put it on the splendid substantial basis it enjoys today. One member was President of the Ontario College of Physicians and Surgeons, and another was one of the organizers of the Laennec Society in Canada and one of its early Presidents.

This illustrates the interest in organization for "medicine"—not just organization for "financial betterment." Our city now has a population of 40,000; with the environs 80,000 to 100,000.* As our clinic partnership operates today we have three surgeons, two obstetricians and gynecologists, three internists, one full-time pediatrician, one full-time anaesthetist, one radiologist, and one certified in both pediatrics and anaesthesiology, an associated ophthalmologist and otolaryngologist, and an associated dentist. Three of the six charter members have died. Two are fully retired, and one, who is partially retired, assists in the management of the clinic and carries on morning office hours. There are two x-ray technicians, one graduate physiotherapist, two qualified pharmacists, two laboratory technicians, seven graduate nurses, an office and secretarial staff of nine, a business manager, two janitors, and one housekeeper. We originally started as a limited company, but during the war a partnership was formed by the members and we, as a partnership, rent the building and services from the Limited Company. We are all on salaries which follow a definite sliding scale and plan of increment, according to seniority, specialty, and the amount of work done. Bonuses are distributed in accordance with annual surplus profits, and individual bonuses for exceptional work may be awarded from time to time. There has been no discrimination against me as a woman in salary matters, except during my first year, when the group, uncertain of my value to them in their organization, hired me for that year "on approval." Since then, I would say I have shared equally with the men, in the proportions as stated above. These years of group practice have been full, interesting years, especially full during the war years, and especially interesting because I have been able to

carry on my two specialties, anaesthesiology and pediatrics, and, of course, some office gynecology.

The wisdom and understanding of the older men and the stimulating new ideas and enthusiasm of the younger, and above all the non-competitive professional and personal associations with them all, have made practice of this type a pleasure which I can recommend most highly to those graduates who have not become wedded to research or teaching, and who are anxious to branch out in the smaller cities of this country.

One conclusion I have drawn from these few years of practice has been that every woman physician, regardless of her specialization, should be prepared to do some gynecology, even though it is just enough to enable her to sort out and refer the major problems. She should see the gynecological patient, once, at least, for that visit may represent the culmination of many nervous and unsuccessful attempts on the part of the patient to seek medical advice, and being examined that day may mean the difference between life and death for that woman. At present a woman physician can "lose face" in smaller communities if she is unwilling or unable to deal with these problems. With the changing times and education of the lay public with regard to specialization, the woman physician may, in the future, never be called upon to do anything but her specialty; but for the time being and in certain localities she will often be asked for help, advice, and treatment, and she should meet these demands in accordance with her Hippocratic Oath.

Recently I asked the president of an organized medical group what requisites he would demand of a woman seeking association with his group, and he replied: (1) She must have good health and physique. (2) She must have ability to create good relations with the public. (3) She must bring something to the group, i.e., she must be able to do something the other members can't or won't do. (4) She must expect no concessions because she is a woman. (5) She must be resourceful, and ready to take her turn "on call." And he added, "She has the right to expect from us the same remuneration for services rendered as the men receive."

In conclusion, organized group practice is definitely the trend in medicine today. There is a place in it for medical women. They should be aware of it and should prepare for it. The establishment of ethical groups with sound prepaid medical insurance is the only hope for the public and the medical profession of avoiding the imposition of a nationally socialized medical plan.

*The total number of medical practitioners in Canada in 1948 (September) was 13,373; approximately 600 of these were women. The ratio was one active physician to 963 population. Ontario has 4,000 physicians, of whom 325 are women.

Medical Women in Finland

Anni Seppanen, M.D.

Until 1878 there were no women physicians in any of the Scandinavian countries, but during that year Rosina Heikel passed the final medical examination in Finland.

Born in 1842, she developed an early interest in medicine when her two brothers became medical students, and at the age of 18 she decided to become a doctor. At that time it was not easy to find a place in Scandinavia where a woman could study anatomy and physiology. For this purpose Rosina Heikel entered the Gymnastic Central Institute in Stockholm, where she studied from 1865 to 1866. In 1867 she attended a midwifery course at the Lying-in Hospital in Helsinki, hoping by this means to attain her goal.

Finally, in 1870, the Helsinki University opened its doors to women for the study of medicine, and the following year Rosina Heikel began her studies in natural history, thus proceeding towards the medical examination. At first she experienced many difficulties, one of which was in her anatomy course. She was not allowed to continue her studies in the dissecting room with the male students, but had to work alone in a small side room. However, in 1878, 13 years from the time she had decided to become a doctor, she had her final examination and was then appointed a district doctor in Helsinki, where she handled mainly gynecological cases. This position she held for over 20 years.

Dr. Seppanen was President of the Finnish Association of Medical Women at the time this article was written.

Study of Dr. Rosina Heikel's life makes one realize she had to suffer many hardships because of isolation, lack of public understanding, and opposition from fellow students. This made her feel she had to fight not only for herself, but also for women who would follow her in the study and practice of medicine. She was always ready to help women doctors and to speak and write for their causes. She was fully convinced that there was a real need for medical women, for the social development of women and children, as well as for treatment of the sick.

Almost 20 years passed before other women doctors appeared in this country. In 1896 two women passed the final medical examination: Ina Rosqvist and Karolina Eskelin.

Dr. Ina Rosqvist, who devoted her life to fighting tuberculosis, worked as the "tuberculosis doctor in Helsinki," where she organized examinations for tuberculosis. Later on, many women followed her in selecting this branch of medical work. At the present moment there are more women doctors working on this disease in Finnish dispensaries or at sanatoria than in any other specialty.

Dr. Karolina Eskelin was the first woman surgeon in Finland. She founded two private hospitals, the first one in the industrial town of Tampere, and later a second one in Helsinki. She made two journeys to the United States where she passed a medical examination in three states and practised for a time in two: Oregon and Massachusetts. Highly esteemed by all her colleagues as a talented and intelligent person, she spent most of the latter part of her life writing books and articles on popular medicine.

At the time the two last mentioned women were studying at the medical university, a notable

change occurred concerning the status of the university studies of women in general, as well as public opinion regarding medical women. Women students no longer felt opposition, but worked together with men students on an equal, friendly basis. Since that time, medical women have had the same opportunities as their male colleagues, both as to examinations and as to positions held. They have gradually assumed their place in the medical field by the side of their male colleagues, and especially during the last two decades their number has increased greatly.

The following table, showing the number of women physicians who passed their final examinations during the period from 1878-1948, clearly reveals this growth:

1878	1
1879-1888	0
1889-1898	2
1899-1908	12
1909-1918	19
1919-1928	46
1929-1938	111
1939-1948	198

The total number of women physicians at the beginning of 1949 was 361. This comprises 19 percent of all Finland's doctors. With a total population of about 4,000,000, there is one physician for every 2,100 persons, and one woman physician for every 11,000 persons.

Women doctors covered various spheres of activity in 1948. These may be broken down percentage-wise as follows:

General practitioners	48.0 percent
Tuberculosis specialists	10.5 percent
Psychiatrists	6.5 percent
Rural community doctors	5.7 percent
Pediatricians	4.6 percent
Internists	3.0 percent
Gynecologists and obstetricians	3.0 percent
Ophthalmologists	3.0 percent

In addition, there is one percent respectively, specializing in dermatology, surgery, x-ray therapy and physical therapy.

Though the need for women specialists is generally recognized by patients, there still seems to be considerable difficulty for women physicians to obtain positions as assistant physicians in some special clinics.

In Finnish hospitals, there are now four women acting as physicians-in-chief, namely, at a psychiatric hospital, a deaconess hospital (an ophthalmologist), a hospital for infectious diseases (a pediatrician), and at a hospital for allergic cases, founded by Dr. Zaida Eriksson-Lihr, (a pediatrician). Also, 15 women have positions as senior physicians at psychiatric hospitals and 14 act as senior physicians at tuberculosis sanatoria.

DR. ROSINA HEIKEL
Finland's first woman doctor

There are also women acting as hospital doctors in some rural communities. In Finland, rural community doctors have a very wide sphere of action. In addition to being public health officers, school doctors, and consulting doctors at maternal and child health centers, they have to act as practitioners in all possible specialties and make calls on patients often within a wide area. At present, there are about 15 rural community women doctors, thus making up 5.7 percent of all such doctors. During the war, women doctors had to work in most of these positions under very trying conditions.

Quite a number of medical women are members of Community Councils and of their Health Boards in towns and in rural areas. Many of them are school physicians at the primary and secondary grade levels.

At the University two women have held the position of professor. Dr. Laimi Leidenius was appointed professor of obstetrics and gynecology in 1930. Well known for her research work on eclampsia and micropathology of uterine cancer, she was also a distinguished and an extraordinarily experienced practitioner. Moreover, she participated in many social activities. She also took an active part in the planning and building of the Women's Clinic in Helsinki. Professor Leidenius died in 1938. The second woman professor, Dr. Hilja Teraskeli, was appointed to the chair of ophthalmology at the University in Turku in 1945.

Among other university teachers are Dr. Eeva Jalavisto,* lecturer in physiology, and Dr. Göta Tingvald-Hannikainen, lecturer in phthisiology. Dr. Elsa Ryti, who died in 1931, was a prominent young lecturer and research worker in bacteriology and serology.

Dr. Göta Tingvald-Hannikainen, in 1932, started the regular tuberculosis examinations of the Helsinki State University students. As one of the experts she took active part in the organization of a general Student Health Welfare in 1946-48. She was among the first physicians to begin tuberculosis examination of school children. In the post-war campaign for tuberculosis prevention by means of BCG vaccination, Finnish women doctors are actively participating in their home country, as well as abroad.

The secretary of the Finnish Cancer Association is a woman, Dr. Helmi Jaakkimainen. Through her initiative, other women doctors are, as already related in this JOURNAL (April, 1947), becoming interested in the prevention of cancer.

In the elections of 1948, Dr. Rakel Jalas was the first woman doctor made a member of the Finnish Parliament. She has been working as a psychiatrist at the Ministry of Social Affairs since 1929. Several important laws have been passed which Dr. Jalas helped to prepare. Among them, a new law concerning maternal allowances by the State to all women who apply for it was recently enacted. She has also been a member of several State commissions considering housing problems, education of social workers, use of legal holidays, etc. Dr. Jalas has been nominated a member of the Finnish section of the World Health Organization.

DR. RAKEL JALAS
Member of Parliament

Men doctors, as well as foreign women colleagues, contend that the achievements of Finnish women doctors are not correlated to their great numbers, at the moment almost 20 percent of the total medical corps. We might answer that the majority of Finnish medical women are still young, and the future will show the results of their work. Moreover, it should be borne in mind that, as in other countries, most Finnish medical women are married. While in 1927, 42 percent were married, in 1948, 58 percent were married or widows; and about 30 percent of those married had three or more children.

In recapitulation, we might say that Finnish women pioneers, with their early hard-won fight for equality between the sexes in the field of medicine, helped tremendously to blaze the trail for medical women throughout the world. And in this small Scandinavian country we find medical women, as they earnestly cope with scientific problems side by side with their brothers in the profession, not only promoting Finnish culture to the best of their ability, but also contributing to the common cultural fund of humanity.

*Now Professor of Physiology—Ed.

Rachel Forster Hospital for Women and Children

SYDNEY, N.S.W., AUSTRALIA

Mary C. Puckey, M.D.

TWENTY-EIGHT YEARS AGO Dr. Lucy Gullett returned from Melbourne after attending the twenty-fifth annual meeting of the Queen Victoria Memorial Hospital (a hospital founded and staffed by women for women and children) full of enthusiasm for their work and a burning ambition to follow in their footsteps. Dr. Gullett and Dr. Biffin, two of Sydney's best known women physicians, forthwith called a meeting, which was attended also by Dame Constance D'Arcy, Dr. Susie O'Reilly, Dr. Margaret Harper, and Dr. Emma Buckley.

At that meeting plans were formulated for the founding of Rachel Forster Hospital for Women and Children, Redfern, New South Wales. Funds were non-existent. Women doctors still had to fight prejudice and were still finding it difficult to get hospital appointments. The new hospital was to overcome these difficulties. It would afford medical women an opportunity to practice their profession and would provide medical, surgical and obstetric treatment for women and children by qualified women medical practitioners.

A sum of £1,000 was raised by the women doctors and their friends. A house, sadly in need of repair, was bought in Surry Hills—the center of Sydney's poorest area—and there The New Hospital for Women opened in January, 1922. The house was so old and dilapidated and funds were so low that the women doctors themselves had to do the cleaning, painting, and many repairs; the building was so shaky that weightier patients, for reasons of safety, were attended to on the ground floor. There was no provision for beds and the work was confined to out-patients. In a few urgent cases, patients were visited in their own homes. In the early years the medical women undertook all the management as well as the medical work, Dr. Lucy Gullett acting as Honorary Secretary.

The first day one patient attended. History does not relate how many doctors were available for that patient, but that first year 2,421 individual patients had attended, including 773 children, showing the need for such a hospital. At the outset a venereal disease clinic was established; this same clinic still functions and has developed into the largest of its type in Australia.

The New Hospital opened as a general medical and surgical hospital and has remained so up to the present, training women in all branches of medicine and surgery. The Directors hope later to build a separate maternity block.

At the first annual general meeting Lady Forster, wife of the Governor General, presided and the first committee was appointed with Lady Anderson as President. This committee undertook the entire management of the hospital and its financial affairs, releasing the medical women to concentrate on the clinical work.

From the outset the hospital managed to balance its budget and to expand. Two years later a thirteen-room house in George Street, Redfern, was purchased for £3,500 and the hospital was renamed the Rachel Forster Hospital for Women and Children, in honour of Her Excellency Lady Forster, who has always taken a great interest in the institution.

In 1925 the first Resident Medical Officer, Dr. Leonie Amphlett, and the first resident Matron, Miss Livingstone, were appointed. The need for accommodation for in-patients was becoming more urgent and, in 1926, Lady Denison opened a new wing free of debt, which would accommodate six patients and the necessary nursing and domestic staff. Additions were made to the out-patient department to cope with the rapidly growing yearly attendances, now 19,086.

By 1931 the hospital was recognized as a public hospital under the Hospitals Act of 1929, a big step forward.

Keeping in mind the necessity for further expansion the hospital's first Secretary, Miss Kate Ogilvie, M.B.E., in 1930 undertook a tour of investigation of hospitals and hospital methods in England and America. Following this visit a ward unit of 20 beds, an operating theater and

Dr. Puckey is Chief Executive Officer, Rachel Forster Hospital.

an out-patient department to handle a daily average of 200 attendances were added.

In pursuance of its policy to increase the scope of the hospital's activities, the Board now decided to establish a social service department, and through the generosity of Miss F. M. Gillespie, the Board sent Miss Ogilvie to London to take the almoner's course in training at St. Thomas's Hospital. Subsequently, in 1934, the Almoner Department was opened, the second to be established in New South Wales.

In 1936 the Board placed before the Hospitals Commission of New South Wales the ambitious project of building immediately a 100-bed hospital with appropriate staff quarters. After many setbacks and much discussion as to advisability of undertaking large scale building in such troublous times the foundation stone of the new building was laid in Pitt Street, Redfern, in August, 1940. Finance was supplied by a Government Guaranteed Loan of £140,000. Lady Wakehurst performed the opening ceremony on December 13, 1941. Patients, however, were not admitted until February, 1942. The delay in admitting patients

DR. LUCY GULLETT

The First Hospital in 1922

was necessitated by unavoidable delay in completing certain sections of the building, owing to wartime conditions and the necessity of providing accommodation in the event of air raids. This was accomplished by providing an emergency theater, wards, and treatment bays in the basement, none of which fortunately were ever needed.

Rachel Forster Hospital was now a hospital of 120 beds provided with all ancillary services and appropriate staff quarters.

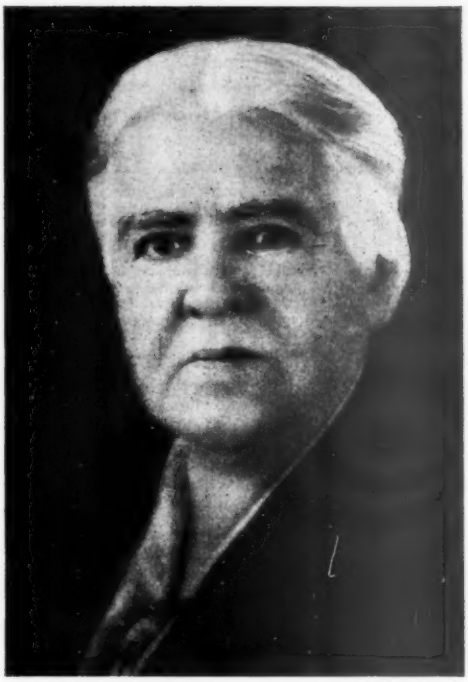
Largely due to the Honourable W. J. McKell, at that time Premier of New South Wales and now Governor General of Australia, sufficient funds were made available to build eighteen additional nurses' bedrooms and a large modern cafeteria at a cost of £75,000; this was completed and in use in February, 1949, and work was commenced on an out-patient department to cost £140,000 in July of the same year.

Such has been the outward and visible sign of the growth of Rachel Forster Hospital.

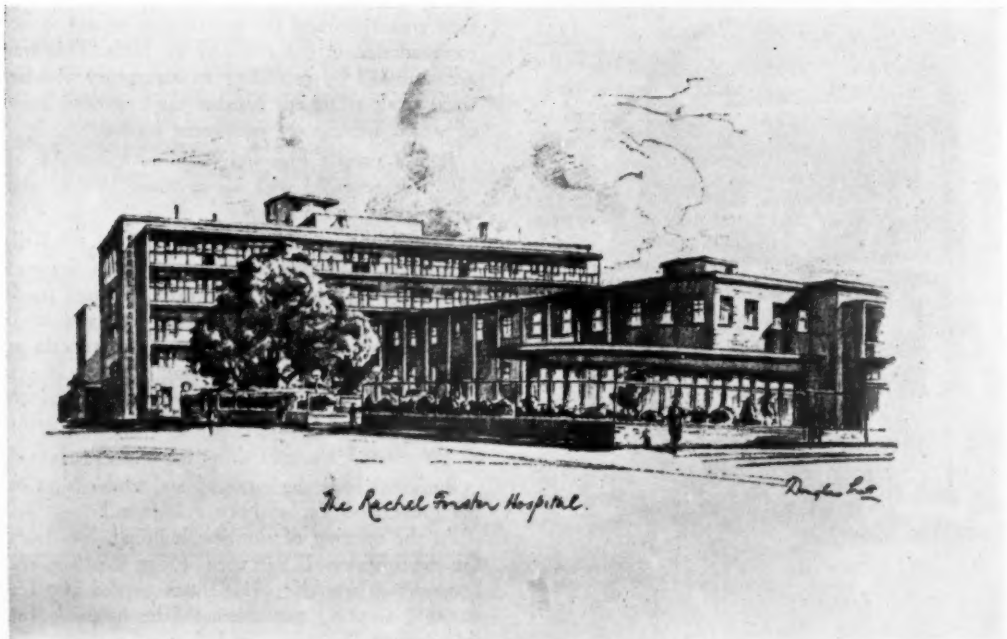
At the opening of the new building, Dr. Lucy Gullett mentioned the need for a convalescent home which would provide much needed rest for patients awaiting admission to the hospital, for those after discharge, and for out-patients not needing hospitalization. The Honorary Medical

Staff of the hospital wishing to honour a founder of the hospital and a very great lady, presented Dr. Gullett with a cheque on her retirement in 1943 from her position as Chairman of the Medical Board, this money to form the nucleus of a fund to establish the Lucy Gullett Convalescent Home. This fund was added to by subscribers and supporters of the hospital and in 1947 a large house set in beautiful grounds in an outer suburb was purchased. The Lucy Gullett Convalescent Home was opened by Dr. Kathleen Cuningham, Chairman of the Medical Board, in November, 1947. This home, accommodating twenty-three patients and staff, and supported entirely by patients' payments and voluntary subscriptions and donations, is operating free of debt.

The medical and academic work of the hospital has kept pace with this expansion in building projects. With the establishment of the Almoner Department in 1934 the hospital was recognized as a training center for almoners by the New South Wales Institute of Hospital Almoners. When the new hospital was opened in 1942 it was registered as a training school for general nurses. In March, 1949, the University of Sydney recognized the Rachel Forster Hospital as a teaching hospital for the general medical and surgical



DR. HARRIET BIFFIN



The Rachel Forster Hospital Today

training of medical students and sixteen fourth-year women students commenced their clinical instruction at the Hospital. Thus The Rachel Forster Hospital became the first hospital of its kind in Australia to be recognized as a school for the clinical instruction of medical undergraduates.

Many hundreds of women have contributed to the growth and development of the Rachel Forster Hospital in skilled service and with financial support. These women have been unstintingly supported in their work by many generous men. Several senior positions on the Honorary Medical Staff are held by distinguished medical men. Men too have been most generous to the hospital in giving financial support and advice.

Rachel Forster Hospital, once established, has been fortunate in securing the sympathetic co-operation and financial support of the Government of New South Wales and the Hospitals Commission. With the expansion of the hospital's activities the Board recognized that certain changes should be made in the administration. Therefore, when Miss Oglivie resigned to take up her duties as almoner at Sydney Hospital, Dr. Mary C. Puckey, in January, was appointed Chief Executive Officer.

The Board has plans in mind for still further expansion and looks forward confidently to the future.

During the War the American Medical Women's Association through the American Women's Hospitals made available a sum of money to the Australian Federation of Medical Women to assist any Australian medical women who had suffered through the War. Fortunately only a portion of this money was necessary for its original purpose, and with the consent of the donors the remaining sum was divided equally between the Queen Victoria Memorial Hospital, Melbourne, and the Rachel Forster Hospital, Sydney. With this gift the Board of the Rachel Forster Hospital will purchase equipment for the new out-patient department. This equipment will bear a suitably inscribed plaque as a permanent reminder of the generosity and kindly thought of the medical women of the United States of America.

NEWS OF WOMEN IN MEDICINE

Austria

The fiftieth anniversary of the opening of medical education to women was celebrated in May. One thousand invitations were sent by the Austrian Medical Women's Association to universities, colleagues, officials, and other interested individuals. It was a celebration in which the Austrian Association of University Women and the Austrian Council of Women joined with the women physicians. * * * Dr. Lore Antoine has been elected one of three chairmen of the "Gesellschaft der Aerzte", the first woman to be thus honored.

Germany

Dr. Gabriele Strecker writes that a German Medical Women's Association was formed in Munich on March 18, and a constitution was adopted by delegates from all the existing groups of medical women in Western Germany. There are 30 women members of the Bonn Parliament, of whom two are physicians, Dr. Victoria Steinbiss, and Dr. Ellinor Hubert.

India

At the beginning of this year Vellore Christian Medical College was granted permanent affiiliation with Madras University as a training college for the M.B., B.S. degree. Vellore is the only Christian medical college in India and Pakistan offering this training. Medical mission work in these countries is dependent for its existence on Vellore College. In Government medical colleges places are allotted on a communal basis, and the small Christian community receives only a few places. The present principal of the college is Dr. Hilda M. Lazarus. The Vellore hospital, with 468 beds, has been built up on the work which Dr. Ida S. Scudder began in 1900. It is a voluntary hospital and receives a small government grant. Forty missionary societies in Britain, U.S.A., Canada, Australia, Sweden, and Denmark are helping to support the College, as are the Friends of Vellore Societies in Great Britain.

PROFESSOR HILDA LLOYD

Siam

Dr. Pierra Vejjabul of Bangkok, in addition to her government and clinic duties, publishes a monthly magazine in Siamese, "Mother and Child" for the benefit of the Siamese mothers.

Turkey

Dr. Gonul Bingol, an internist and the first woman physician in the Police Department, has been elected General Secretary of the Turkish Cancer Association, Ankara. She is a graduate of the Istanbul University Faculty of Medicine. * * * According to statistics from the Turkish Ministry of Health there are 305 women physicians in Turkey (November 29, 1949). Of these 208 are specialists: 64 in pediatrics, 54 in internal medicine, 45 in gynecology and obstetrics, 9 in surgery, 8 in pathology, 7 in psychiatry and neurology, 6 in ophthalmology, 5 in bacteriology, 4 in otolaryngology, 2 in radiology, 2 in biochemistry, 1 in dermatology, and 1 in physiotherapy.

England

Professor Hilda Lloyd, recently installed as President of the Royal College of Obstetricians and Gynaecologists, is the first woman to be elected president of any of the three English Royal Colleges—Physicians, Surgeons, and Obstetricians and Gynaecologists. Dr. Lloyd is Professor of Obstetrics and Gynaecology in the United Birmingham Hospitals and the University of Birmingham, and Senior Surgeon at the Women's Hospital and Maternity Hospital there, as well as Consulting Gynaecologist at several other hospitals near Birmingham. In the National Health Service, she serves on the Maternity Services, Planning, Consultants', and other committees of the Regional Hospital Board; and on several other local hospital boards. Her present honor is a well-deserved one, and crowns a career of hard work and many friendships. In the years between the World Wars, she built up a large private practice in addition to her hospital work. Since her appointment in 1943 as Professor of Obstetrics and Gynaecology, she has had the responsibility of directing the training of medical students and young doctors of both sexes in these important subjects. Professor Lloyd has been an active member of the Medical Women's Federation of Great Britain since its foundation, and has served on the Council and as a Vice-President.

China

Annual Report of the Marguerite T. Doane Tumor Service October, 1948, to September, 1949

Dr. Katherine Li, Director, has reported that during the year 140 in-patients were admitted and 1,887 deep x-ray treatments were given to 188 patients, some of whom were not hospitalized. Among the cases treated were 157 of cancer of the cervix, 5 of cancer of the corpus, and 3 of cancer of the breast.

Ten patients were discharged as cured and 120 were improved.

The Tumor Service was fortunate in securing a permanent resident, Dr. W. M. Teng, as well as a rotating resident, and these additions to the staff made it possible to begin the use of intravaginal deep x-ray in the treatment of cancer of the cervix. The results were encouraging. Deep therapy has been employed also for certain types of infections.

A considerable increase in the number of patients was noted during the year, as well as an increase in the variety of conditions.

Denmark

Mrs. Eugenie Andersen, Ambassador from the United States, spoke in Danish on Mother's Day (in Denmark May 14) over the Danish State Radio and said: "The mothers in our free, democratic countries, in even higher degree perhaps than other people, have the responsibility to see to it that our children develop a deep understanding of our democratic ideals. No form of democracy can live on without firm belief in the worth of the individual child and thus in the individual citizen. Americans do not believe either that it is necessary to bring up children to dictatorship and war. But we are firmly resolved to defend our way of life and our people. The five years' fight was not the first time that Denmark demonstrated the courage and valor of her sons and daughters. But those years gave the best proof of the inner strength and practical idealism which Danish mothers have instilled in their children."

United States of America

MARTHA M. ELIOT, M.D., Assistant Director General of the World Health Organization, is President of the National Conference of Social Work which held its 77th annual meeting at Atlantic City in April. Dr. Eliot was quoted as advocating a partnership of groups working for international health and those promoting international economic development. She said: "The world cannot ride to economic health on the backs of unhealthy people."

HELEN B. TAUSSIG, M.D., Associate Professor of Pediatrics at Johns Hopkins University, is one of 21 active members added to the roll of the Association of American Physicians. This 63-year-old organization limits its membership to 250. Dr. Taussig is the first woman to be elected.

ELISE S. L'ESPERANCE, M.D., was recently appointed Clinical Professor in the Department of Preventive Medicine, Cornell University Medical College, New York.

The first woman president of a county medical society in Wisconsin was recently installed by Racine County. BEATRICE O. JONES, M.D., the new Racine County President is a pediatrician. Dr. Jones served as secretary of the society for 11 years, but retired from that position three years ago. She is a graduate of Rush Medical School. A member of the Board of Education, she serves as their Chairman of Health and Instruction and as a member of the Finance Committee.

LEONA BRANDES YEAGER, M.D., a member of Branch Two, Chicago, has been named Director of Student Health of the Northwestern University Health Service.

GRACE S. MOUNTJOY, M.D., St. Louis, is a member of the Council of the Southern Medical Association. She is also Chairman of Women Physicians for the next meeting of the organization. This will be held in St. Louis Nov. 13-16.

MYRTLE M. WILCOX, M.D., was elected President of the Broome County Chapter of the American Academy of General Practice at the organizational meeting. FLORENCE WARNER, M.D., was made a Director of this chapter.

The New York and Brooklyn Regional Fracture Committee of the American College of Surgeons sponsored a New York State Regional Fracture-Trauma Day April 29 at the Lenox Hill Hospital. Among the papers presented was one by BARBARA STIMSON, M.D., Poughkeepsie, on "Highway Injuries."

MAY CRAVATH WHARTON, M.D., Pleasant Hill, Tennessee, announces that "Uplands," the Cumberland Mountain Sanatorium which she founded in 1922, will now be devoted to the care of the chronically ill. MARGARET K. STEWART, M.D., is Resident Physician.

Pakistan

A new modern 350-bed Holy Family Hospital in Rawalpindi, Pakistan, has been recently opened by the Medical Mission Sisters of Philadelphia, Pennsylvania. The new hospital has the distinction of being the largest Catholic hospital and training center for nurses in the whole of Pakistan. In it, men, women, and children of all creeds and classes will receive medical care. SR. M. ALMA LALINSKY, M.D., graduate of Woman's Medical School in Philadelphia and Doctor-in-Charge at Holy Family Hospital, acted as chairman at the official opening ceremony held March 25. Mohammedan Major General S.M.A. Faruki, Director General Medical Services of the Pakistan Army, was guest speaker and performed the formal opening. Guests of honor included the Commander-in-Chief of the Pakistan Army, General Sir Douglas Gracey, and Lady Gracey, and the Commissioner of Rawalpindi District, Hadi Hussein. The Medical Mission Sisters are a religious group dedicated to the professional medical care of the sick. In this, the 25th year of their work, the Sisters conduct twelve medical centers in India, Pakistan, Africa, Indonesia, and the United States.

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

VIth Congress—Philadelphia, Pa., U.S.A.—September 10-16, 1950

TENTATIVE PROGRAM

Sunday, September 10
8:00-10:00 p.m.: First Executive Meeting, Lounge W.M.C.

Monday, September 11
10:30 a.m.: First Council Meeting, Lounge W.M.C.
9:00 a.m.-5:00 p.m.: Registration, Lobby W.M.C.
For Non-Council Members: Sight seeing trips and visits to Hospitals
2:30 p.m.: Official opening, College of Physicians
4:00 or 5:00 p.m.: First General Assembly, College of Physicians

Tuesday, September 12
10:00 a.m.: Scientific Meeting, Auditorium W.M.C.
Lunch, W.M.C.
2:00-4:30 p.m.: Scientific Meeting continued, W.M.C.
6:30 p.m.: Dinner at home of Dr. Elizabeth Waugh

Wednesday, September 13
Morning: Woman's Medical College and Hospital, Demonstrations and Clinics
Lunch, W.M.C.
3:00 p.m.: Opening exercises of College, Auditorium, W.M.C.
Dinner, Guests of College, at Philadelphia Cricket Club

Thursday, September 14
10:00 a.m. and 2:00 p.m.: Scientific Meetings, Auditorium W.M.C.
Lunch, W.M.C.
4:00 p.m.: Tea, at University Museum

Friday, September 15
10:00 a.m.: Second Council Meeting, Lounge W.M.C.
3:00 p.m.: Second General Assembly, Auditorium W.M.C.
Dinner, Barclay or Warwick Hotel

Saturday, September 16
10:00 a.m.: Second Executive Meeting, Lounge W.M.C.
Sightseeing

Canada welcomes the visiting women physicians to meetings in Toronto on September 5 and 6, 1950. Members from the United States are cordially invited to join the sightseeing trip and dinner at Niagara Falls on September 6th. If you plan to participate in the September 6th activities, kindly notify Dr. Agnes White, 138 Sherbourne Street, Toronto, Canada.

The Women's Medical Association of New York City has arranged the following schedule: Thursday evening, September 7, a Get-Acquainted Buffet supper on the roof of Beekman Towers Hotel; Friday, September 8, at 9:30 a.m., a scientific program at New York Hospital-Cornell Medical Center; speakers will be Dr. Edith Lincoln, Dr. May Wilson, Dr. Ann Carter, Dr. Mary Payne. This will be followed by luncheon, then a tour of the Medical Center. Thursday afternoon, there will be a scientific program at Memorial Hospital, tea, and a tour of the hospital. In the evening, dinner at the Cosmopolitan Club. Saturday will be devoted to sightseeing. Plans also include visits to the New York Infirmary and to United Nations Headquarters at Lake Success, New York. Sunday morning, breakfast at home of Dr. Reid, thence by bus to Philadelphia.

Members of the International Association who are expecting to come to New York and Philadelphia are requested to obtain registration blanks from their national corresponding secretary or from Dr. Margaret M. Wurts, 27 Wellesley Road, Montclair, New Jersey, U.S.A.

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

ASSOCIATION NEWS AND ANNOUNCEMENTS

THE PRESIDENT'S MESSAGE

As your new president I extend greetings to every member of the American Medical Women's Association. In particular I wish to welcome you who are new members into our fellowship and suggest that you keep in close touch with the Association by reading the monthly Journal.

The outstanding event on our 1950 program is the Sixth Congress of the Medical Women's International Association meeting in Philadelphia September 10 to 16. The Woman's Medical College of Pennsylvania, which this year is celebrating the Centennial Anniversary of its founding, has invited the International Association to make the College its headquarters for this meeting. The women physicians of Philadelphia look forward to this event with great pride, pleasure, and anticipation. They consider it a special honor to be hostesses to the women from abroad. However, the Philadelphia women wish to share this privilege with all members of the American Medical Women's Association. We urge each of you to attend this Congress and join in entertaining our visitors from other countries.

This is an unusual opportunity to promote good international medical relations. Do make an effort to come and help to give the international group a royal welcome. The Woman's Medical College also invites you to join in its Centennial celebration. The May, 1950, issue of the Journal gives details of the program and hotel arrangements.

Elizabeth S. Waugh

Elizabeth S. Waugh, M.D.

WE WELCOME THESE NEW MEMBERS

Canada

Agnes King Moffat, M.D.—327 Charlotte Street, Peterborough, Ontario; McGill University, 1931. Specialty: Pediatrics.

Alaska

Virginia M. Cobb, M.D.—Box 1972, Juneau; College of Physicians and Surgeons, Columbia University, 1929. Specialty: Pediatrics.

Arizona

Lucille M. Dagres, M.D.—543 East McDowell Rd., Phoenix; Creighton University School of Medicine, 1940.

California

Helen Mackler, M.D.—568 Haberfelde Building, Bakersfield; University of California Medical School, 1937. Specialty: Internal Medicine.

Lucille Brown May, M.D.—2026 17th Street, Bakersfield; University of California Medical School, 1924. Specialty: Obstetrics.

Rosemary O'Donnell Brunetti, M.D.—1120 Euclid Avenue, Berkeley 8; Woman's Medical College of Pennsylvania, 1947. Specialty: Public Health.

Dorothy Fraser Wheeler, M.D.—198 East Third Street, Chico; University of Michigan Medical School, 1931. Specialty: Pediatrics.

Yvonne Champreux, M.D.—P.O. Box 2605, Carmel; Stanford University School of Medicine, 1944.

Anetta Truman McGuffin, M.D.—1632 Morena Drive, Glendale 7; College of Medical Evangelists, 1936. Specialty: Internal Medicine.

Miriam Ottman Vinnard, M.D.—1018 Gretna Green Way, Los Angeles 49; College of Medical Evangelists, 1942. Specialty: Anesthesia.

Harriett Bulpitt Randall, M.D.—11339 Bolas Avenue, West Los Angeles; College of Medical Evangelists, 1928. Specialty: Pediatrics.

Dorothy Lottridge, M.D.—1543 "O" Street, Fresno; Woman's Medical College of Pennsylvania, 1926.

Eleanor Nelson, M.D.—371 30th Street, Oakland 9; University of California Medical School, 1938. Specialty: Obstetrics.

Margaret Soars Sedam, M.D.—511 Brookside Avenue, Redlands; Woman's Medical College of Pennsylvania, 1926. Specialty: Pediatrics.

Thelma Gilbert Harmon, M.D.—2000 Van Ness Avenue, San Francisco 9; University of California Medical School, 1931. Specialty: Ear, Nose, and Throat.

Alma Pennington, M.D.—909 Hyde Street, San Francisco 9; University of California Medical School, 1917.

Lydia J. Shimkin, M.D.—One Parker Avenue, San Francisco 18; Tomsk Imperial University of Siberia, 1913.

Mildred Francis Wehrly, M.D.—218 South Main Street, Santa Ana; University of Southern California Medical School, 1945. Specialty: Radiology.

Frances M. McKay, M.D.—122 Locust Street, Santa Cruz; Creighton University School of Medicine, 1938.

Debora Pineles, M.D.—212 West Main Street, Visalia; Medical College of Virginia, 1939.

Lucy K. Laurence, M.D.—311 Bank of America Building, Whittier; College of Medical Evangelists, 1940. Specialty: Obstetrics.

Idaho

Jane McMahan Cox, M.D.—311 Fifth Street, Lewiston; Temple University School of Medicine, 1945.

Iowa

Ethel Shepherd Dana, M.D.—208 East Second Street, Ottumwa; Cornell University Medical College, 1943. Specialty: Obstetrics.

Louisiana

Margaret Lynn Churchill, M.D.—704 Maison Blanche Building, New Orleans 16; Louisiana State University School of Medicine, 1945. Specialty: Obstetrics.

Maine

Mary Miller Dietrich, M.D.—Orrington; Tufts College Medical School, 1945.

Gisela K. Davidson, M.D.—53 Vincent Street, South Portland; University of Vienna Medical School, 1935. Specialty: Internal Medicine.

Maryland

Caroline A. Shandler, M.D.—615 North Wolfe Street, Baltimore 5; Yale University School of Medicine, 1933. Specialty: Pediatrics.

Eugenie E. Phillips, M.D.—1612 Edmondson Avenue, Baltimore 23; Meharry Medical College, 1944. Specialty: Obstetrics.

Massachusetts

Lucile Lord-Heinstein, M.D.—1269 Commonwealth Avenue, Allston, 34; Tufts College Medical School, 1927.

Isabel S. Money, M.D.—1180 Beacon Street, Brookline 46; Boston University School of Medicine, 1940. Specialty: Obstetrics.

Mary Isabel Tompkins, M.D.—1180 Beacon Street, Brookline 46; Tufts College Medical School, 1933. Specialty: Gynecology.

Eleanore G. Marchand, M.D.—19 Longfellow Rd., Cambridge 38; Tufts College Medical School. Specialty: Anesthesiology.

Elsie S. Neustadt, M.D.—27 Avon Way, Quincy 69; University of Leipzig Medical School, 1924. Specialty: Neurology.

Michigan

Margaret Bell, M.D.—15 Geddes Heights, Ann Arbor; Rush Medical College, University of Chicago, 1921.

Carol Platz, M.D.—11368 Kelly Road at Hayes, Detroit 24; Stritch School of Medicine of Loyola University, 1943. Specialty: Obstetrics.

Estelle P. Wachtel-Torres, M.D.—3985 Caniff Avenue, Detroit 12; Wayne University College of Medicine, 1945.

New Jersey

Charlotte A. Kleiner, M.D.—384 Henry Street, Fairview; New York University College of Medicine, 1945.

Laura E. Morrow, M.D.—197 Passaic Avenue, Passaic; University of Pennsylvania School of Medicine, 1937. Specialty: Psychiatry.

Ruth Zuckerman, M.D.—309 Johnson Avenue, Teaneck; New York University College of Medicine, 1940. Specialty: Dermatology.

New York

Grace McLean Abbate, M.D.—9 Garden Place, Brooklyn 2; Long Island College of Medicine, 1932. Specialty: Psychoanalysis.

Jane Carroll Brady, M.D.—240 Morris Avenue, Buffalo 14; University of Buffalo School of Medicine, 1945.

Edith Gutman, M.D.—38-32 Browne Street, Flushing; University of Vienna School of Medicine, 1937.

Janith Stewart Kice, M.D.—131 Fulton Avenue, Hempstead; University of Vermont College of Medicine, 1937. Specialty: Dermatology.

Irene Garrow, M.D.—83-53 164th Street, Jamaica; New York University College of Medicine, 1937. Specialty: Pathology.

Dorothy H. Andersen, M.D.—106 Cabrini Boulevard, New York 33; Johns Hopkins University School of Medicine. Specialty: Pathology.

Sara Katherine Blake, M.D.—121 St. Nicholas Avenue, New York 26; Meharry Medical College, 1942. Specialty: Anesthesiology.

Julia Fischler, M.D.—508 West 166th Street, New York 32; University of Vienna Medical School, 1931.

Margaret M. Rice, M.D.—11 Cooper Street, New York 34; New York Medical College, 1947. Specialty: Peditarics.

Elizabeth Van R. Gillette, M.D.—254 Union St., Schenectady 5; University of the State of New York Medical College, 1898.

North Carolina

Margaret L. Owen, M.D.—16 Division Street, Canton; University of Pennsylvania School of Medicine, 1932.

Ohio

Margaret Hyde Moore, M.D.—1241 Jefferson Avenue, Akron; Johns Hopkins University School of Medicine, 1939. Specialty: Public Health.

Elsie K. Snell, M.D.—Church Street, Amherst; New York University College of Medicine, 1933.

Mildred Hickey Shelly, M.D.—9818 Heath Avenue, Cleveland 4; Creighton University School of Medicine, 1942. Specialty: Psychiatry.

Myrtle Collyns Dineen, M.D.—701 East Main Street, Kent; University of Michigan Medical School, 1941.

Pennsylvania

Frances C. Schaeffer, M.D.—26 North Eighth Street, Allentown; University of Pennsylvania School of Medicine, 1942. Specialty: Obstetrics.

Anna M. Ziegler, M.D.—31 South 9th Street, Allentown; New York University College of Medicine, 1933. Specialty: Obstetrics.

Eleanor Triboletti, M.D.—300 West 9th Street, Chester; Woman's Medical College of Pennsylvania, 1944.

Ruth E. Duffy, M.D.—Devereux Schools, Devon; Woman's Medical College of Pennsylvania, 1935. Specialty: Internal Medicine.

C. Bernardin Quinn, M.D.—491 York Road, Jenkintown; Woman's Medical College of Pennsylvania, 1937. Specialty: Pediatrics.

Anna Mary Booth, M.D.—Middleburg, Snyder County; Women's Medical College of Pennsylvania, 1945. Specialty: Pathology.

Helen O. Dickens, M.D.—1512 Oxford Street, Philadelphia 21; University of Illinois College of Medicine, 1934. Specialty: Obstetrics.

Marion Bozarth Kolbye, M.D.—618 West Lehigh Avenue, Philadelphia 33; Woman's Medical College, 1932. Specialty: Obstetrics.

Mary Miller Livezey, M.D.—133 South 36th Street, Philadelphia 4; University of Pennsylvania School of Medicine, 1937. Specialty: Internal Medicine.

Sylvia A. Mazer, M.D.—136 South 16th Street, Philadelphia 2; Woman's Medical College of Pennsylvania, 1938. Specialty: Obstetrics.

Margaret J. Nash, M.D.—3513 North 23rd Street, Philadelphia 40; University of Pennsylvania School of Medicine, 1925.

(List Continued on Page 304)

BOOK NOTICES

(Editor's Note:—These reviews represent the individual opinions of the reviews and not necessarily those of the members of the Editorial Board of the JOURNAL.)

CARE OF THE SURGICAL PATIENT. By Jacob Fine, Surgeon-in-Chief, Beth Israel Hospital; Professor of Surgery at Beth Israel Hospital, Harvard Medical School. Price, $8.00. Pp. 544. Illustrated. W. B. Saunders Company, Philadelphia and London, 1949.

This is an extremely useful book, containing much valuable information in a condensed form. Perhaps its greatest usefulness will be as a handbook for graduates or as a review for older physicians. The book is divided, for convenience, into general considerations, such as fluid and electrolyte balance and surgical infections, and into surgical care of specific conditions and definitive regions. There are special features not usually considered in surgical textbooks; for example, there is a chapter devoted to the medical emergencies most commonly encountered in surgical patients. Much factual information often omitted in a general treatise is contained here, as well as the methodology of most frequently used laboratory tests.

In criticism, it may be said that since the author has covered a wide field, in some instances the treatment is necessarily superficial. Nevertheless, the book is completely up-to-date and well worth adding to a surgeon's library.

—Annella Brown, M.D.

PROCEEDINGS OF THE FIRST CLINICAL ACTH CONFERENCE. Edited by John R. Mote, M.D., Medical Director, Armour Laboratories. 178 contributors. Pp. 624, 414 illustrations. Price, $5.50. The Blakiston Company, Philadelphia, 1950.

One of the most fascinating chapters in medical history is being written today by research workers who have for the past three years been studying the effects of ACTH (adrenocorticotrophin) on normal human beings and upon those with a variety of diseases.

In the fall of 1946, the Armour Laboratories supplied Dr. George W. Thorn with ACTH for a study of its physiologic effects. Since that time as the amount of available material has increased, many other workers in different parts of the country have added to our knowledge. Armour and Company are to be congratulated on assembling these workers for the First ACTH Conference in Chicago, October, 1949. This volume is a report of the papers presented, together with discussions, and therefore represents the best and latest opinions in this field. It is a very valuable contribution to the reference literature on this most interesting subject.

—Leonora M. Andersen, M.D.

ORAL AND DENTAL DIAGNOSIS. By Kurt H. Thomas, D.M.D., F.D.S.R.C.S., Eng., Professor of Oral Surgery emeritus and Brackett Professor of all Pathology, Lecturer on Oral Surgery, University of Pennsylvania Graduate School of Medicine. Price, $9.50. Pp. 563. Illustrated. W. B. Saunders Company, Philadelphia, 1949.

This is the third edition and second revision of a scholarly work which has become deservedly popular. Each revision has enlarged its scope and it is to be expected that the second enlargement, like the first, will increase its popularity.

Although planned primarily as a textbook on diagnosis in order to fill the need indicated by the Committee on Survey of the Dental Curriculum of the American Association of Dental Schools, it has been more than that from the very beginning.

Emphasis was naturally on diagnosis, but the book also contained much material dealing with therapeutics. It was useful, therefore, not only to teachers and students, but to the dental profession generally. It is this part of the book, the part having appeal to the practitioner, that has been mainly enlarged in the two revisions, thus increasing its value to the profession as a whole.

In this second revision of "Oral and Dental Diagnosis," the emphasis is still on diagnosis, but in the part dealing with therapeutics, Dr. Thomas discusses the latest methods developed by leaders of the profession, bringing together in one volume the best thought on the subject. The book is therefore a MUST for every dental practitioner.

—Anna P. Boudin, D.D.S.

DOCTOR AND PATIENT AND THE LAW. By Louis J. Regan, M.D., LL.B., Professor of Legal Medicine, College of Medical Evangelists; Consulting Staff, Hollywood Presbyterian Hospital, Los Angeles, Calif. Second edition, Pp. 545. Price, $10.00. The C. V. Mosby Company, St. Louis, 1949.

The purpose of this book is to give consideration to the more important legal problems which arise from the physician-patient relationship. The author points out that the incidence of malpractice claims rises during an economic depression. It is his belief that there will be few instances of injury to patients resulting from carelessness of doctors when the moral and ethical standards of practitioners are consistently high—and also, that there will be fewer instances of injury to doctors resulting from misguided or malicious patients when physicians understand fully how to protect themselves under the law. The remainder of the book outlines situations in which malpractice most often occurs. He stresses the importance of proper consent for specific operations and for autopsy, privileged communications, liability for act of partner or employee, liability of charitable, private, and public hospital for care of patient and for acts of attending physician. The next chapter deals with the physician as expert witness and the following discusses the importance of expert testimony. Malpractice does not exist unless it is proved that the patient has been injured by the negligence of the doctor. Various types of evidence are next discussed.

Problems which arise in the course of everyday practice, such as abortion, are considered; when is it justifiable and permissible? Other problems are presented, adoption, artificial insemination, blood grouping as a test for paternity, contraceptive statutes, criminal malpractice, dying declarations, payment of professional services, insane persons, insurance, license to practice, and narcotics.

One chapter gives examples of forms which are helpful in the various situations which arise in the doctor-patient relationship, such as consent for operation, treatment of patient who has aborted, patient fails to keep appointment or fails to follow treatment, patient discharges physician or physician withdraws from case. An important chapter deals with Self-testing in Malpractice Vulnerability in which the doctor is urged to analyze his own ability, his equip-

ment and records, and the skill of his employees. Measures are outlined which have been effective in educating the physician in ways to avoid malpractice claims; the importance of keeping complete records is stressed, and emphasis is placed upon the danger of making comments or criticisms of other physicians, especially of those who may have previously handled the case. It is stated that the latter accounts for probably 50 to 80 percent of all suits for malpractice.

The most frequent types of allegations according to specialty are next considered and many cases are cited which illustrate the most usual forms of malpractice suits. The author calls for a strong defense which exonerates the physician completely as being necessary in order to reduce the number of malpractice suits. This book should be very helpful to the practitioner in pointing out legal pitfalls which otherwise he would not foresee.

—Ada Chree Reid, M.D.

MEDICAL STATE BOARD: QUESTIONS AND ANSWERS. By R. Max Goepp, M.D., former Professor of Clinical Medicine, Graduate School of the University of Pennsylvania, and Harrison F. Flippen, M.D., Associate Professor of Medicine at the Graduate School of the University of Pennsylvania, with six editorial consultants. 8th edition, 595 pp., 68-page index. Price, $7.00. W. B. Saunders Company, Philadelphia, 1949.

This is the eighth edition of a book which has since 1907 been the medical students' guide in "boning up" for state board examinations. Except for the section on anatomy which was thoroughly revised in the seventh edition, practically all the chapters have been rewritten. An editorial board of specialists has been formed so that the important advances in the various fields of medicine have been considered in this revision. A section on psychiatry has been added for the first time. Today's graduates in medicine will find—as have their predecessors—that "Goepp's" has the answers to the questions likely to be asked in the state board examinations.

—Ada Chree Reid, M.D.

RESEARCH FELLOWSHIPS IN PEDIATRICS

Dr. Bert Ratner and members of the departments of pediatrics and immunology of New York Medical College announce two full-time research fellowships in pediatrics, both carrying a stipend of $2,000 per year. One starts July 1, the other on January 1.

Applicants must be certified in pediatrics or have the requirements for certification. Fellowships run from one to two years and will consist of training in immunology and animal research pertaining to hypersensitivity. Intensive study will be made of allergic children, including methods of skin testing, laboratory work and clinical follow-up.

Applicants who have had previous training in chemistry and/or immunology and who desire a research career will have preference. Application should be made to the Dean of New York Medical College, 106th Street and Fifth Avenue, New York, N. Y.

NEW MEMBERS

Continued from page 302

Helen Frances Stochen, M.D.—1832 Spruce Street, Philadelphia 3; Temple University School of Medicine, 1944. Specialty: Psychiatry.

Pauline V. Stocks, M.D.—5025 Penn Street, Philadelphia; University of Kansas School of Medicine, 1930. Specialty: Obstetrics.

Marcelle J. Bordes, M.D.—Pine Grove; Long Island College of Medicine, 1940.

Mary K. Helz, M.D.—4715 Fifth Avenue, Pittsburgh 13; University of Pittsburgh School of Medicine, 1945. Specialty: Internal Medicine.

Irene A. Shank, M.D.—4733 Bardenville Road, Pittsburgh 27; Wayne University College of Medicine, 1938. Specialty: Anesthesiology.

Margaret Hay Edwards, M.D.—2048 Elk Avenue, Pottsville; Temple University School of Medicine, 1944. Specialty: Internal Medicine.

Mary Dickson Varker, M.D.—604 Sussex Road, Wynnewood; Woman's Medical College of Pennsylvania, 1925.

Margaret E. Crofton, M.D.—141 East Market St., York; University of Tennessee College of Medicine, 1942. Specialty: Internal Medicine.

Tennessee

Margherita C. Ciaramelli, M.D.—208 Vermont Avenue, Oak Ridge; New York University College of Medicine, 1943. Specialty: Anesthesiology.

Texas

Evelyn Gass Powers, M.D.—3208 Hayden Street, Amarillo; Baylor University College of Medicine, 1925. Specialty: Gynecology.

Mary Ghormley, M.D.—615 Oliver Court, Corpus Christi; University of Texas School of Medicine, 1940.

Virginia Blocker, M.D.—University of Texas School of Medicine, Galveston; University of Texas School of Medicine, 1939. Specialty: Internal Medicine.

Elizabeth D. Talley, M.D.—3758 North Shepherd Drive, Houston; University of Texas School of Medicine, 1945.

Washington

Mildred Mumby, M.D.—1872 Hamlin Street, Seattle 2; University of Oregon Medical School, 1925. Specialty: Dermatology.

Elizabeth Marquis Peterson, M.D.—2609 58th Avenue, S.W., Seattle 6; College of Physicians and Surgeons, Columbia University, 1936.

NEW ASSOCIATE MEMBER

Marguerite Prince Sykes, M.D.—435 East 52nd Street, New York; New York University College of Medicine, 1948.

HELEN JOHNSTON, M.D.,
Chairman, Membership Committee

REPORTERS WANTED!

If any of our readers plan to attend the Second Congress of the International Society of Hematology, Cambridge, England, August 21 to 26, or the International Congress of Psychiatry, Paris, October 4 to 12, and will report the Proceedings for the JOURNAL, kindly communicate immediately with Dr. Margaret S. Tenbrinck, 235 East 22 Street, New York 10, N. Y., so that she may send them their credentials.

CLASSIFIED ADVERTISING

DOCTOR WANTED

Will sacrifice Inn—suitable private hospital; 19 bedrooms, 12 baths, modern equipment, in healthful Blue Ridge. No doctor in town. Mrs. C. W. Mason, Saluda, North Carolina.

MANUSCRIPT TYPING

Manuscript typing done by typist experienced in medical terminology. Reasonable rates and prompt delivery.—Mrs. V. Butler, 805 Broadway, Newark, N. J.

We regret . . .

Although we strive to keep our subscribers happy and never without a copy of the current issue of the JOURNAL—we regret that it is not possible to change mailing addresses for summer or winter holidays.—Ed.

If you desire a new location or position . . .

If you need an assistant or associate, partner or successor . . .

If you want to buy or sell a practice, apparatus, instruments or books . . .

The J O U R N A L makes available to you through its classified columns a concentrated assemblage of those throughout the United States who would be interested in your offer.

If yours is an ethical proposition for medical women and you're looking for the natural medium to advertise it, these columns are published for you. Rates on request.

Journal of
The American Medical Women's Association
Suite 3B, 118 Riverside Drive
New York 24, N. Y.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

APPLICATION FOR MEMBERSHIP

Name _____

(Please print as you wish it to appear in the Year Book.)

Address _____

Medical School _____ Year of Graduation _____

Licensed in County _____ State _____

Specialty _____ Certified _____

Place of Birth _____

Date of Birth _____ Marital Status _____

To what Medical Societies do you belong? _____

Check Membership desired:

☐ National—Dues $5.00 yearly, payable January 1st.

☐ Life Membership — $100.00. (Payable in two installments, if desired.)

☐ Associate, no dues.

☐ Branch—Dues prescribed by Branch are not included in the above.

☐ If member-at-large check here.

☐ Memorial—$500.00.

Annual, Life, Associate, and Junior members receive the official publications. Annual and Life members receive membership in the Medical Women's International Association.

Endorsed by: 1. _____ M.D., Member A.M.W.A.

2. _____ M.D., Member A.M.W.A.

(Membership in County or State Medical Society may be accepted for above endorsements.)

Date _____ Signature _____

Checks must accompany application. Mail to Treasurer: Mary Riggs Noble, M.D., Bowmansdale, Cumberland County, Pennsylvania. Make checks payable to American Medical Women's Association, Inc.

The Journal of the

AMERICAN MEDICAL WOMEN'S ASSOCIATION

invites your subscription

THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION
is published monthly, subscription $5.00 per year, ($9.00 for two years).

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION
118 Riverside Drive, New York 24, N. Y.
Send the JOURNAL for one year (Please check)
two years

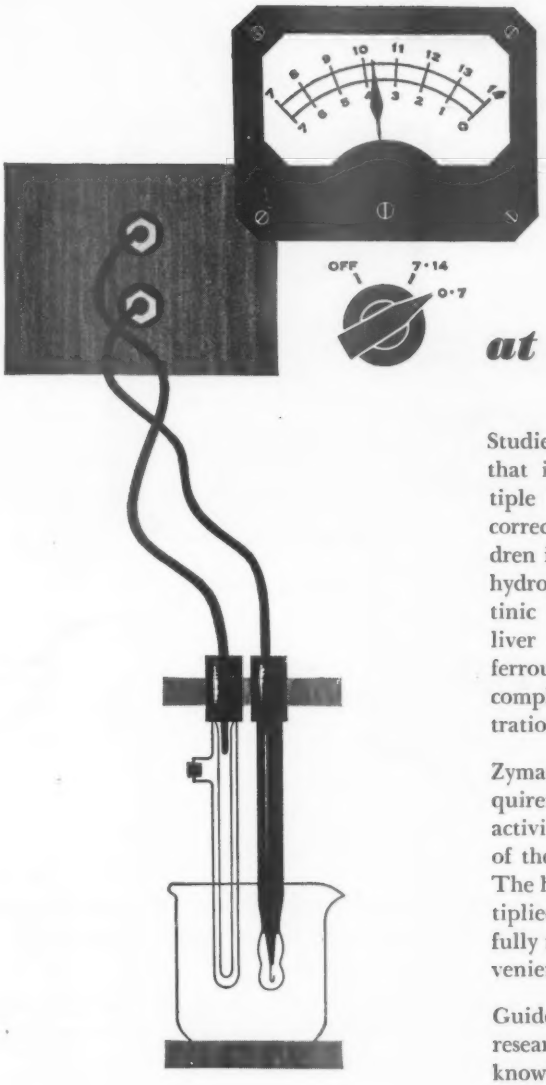
NAME .....

ADDRESS .....

(Check must accompany subscription request.)

Below is noted a list of the firms who at the present time are advertising in the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION. We appreciate their interest in our publication and ask our members to favor them whenever possible.

Abbott Laboratories
Ayerst, McKenna & Harrison, Ltd.
Beech-Nut Packing Company
Borden Company
Ciba Pharmaceutical Products, Inc.
Coca-Cola Company
Desitin Chemical Co.
Eaton Laboratories, Inc.
Hoffman-La Roche, Inc.
Holland-Rantos Co., Inc.
Johnson & Johnson
Lanteen Medical Laboratories, Inc.
Eli Lilly & Company
Mead Johnson Company
Merck & Company, Inc.
Philip Morris & Co., Ltd., Inc.
Ortho Pharmaceutical Corporation
Parke, Davis & Company
Picker X-Ray Corporation
Schering Corporation
Smith, Kline & French Laboratories
E. R. Squibb and Sons
R. J. Strasenburgh Company
Martin H. Smith Company
Swift & Company
Tampax, Incorporated
Upjohn Company
William R. Warner & Co., Inc.
Winthrop-Stearns, Inc.



at a pH of 3.8

Studies by Upjohn research workers show that it is possible to combine the multiple hematopoietic factors required for correction of anemia in infants and children in a stable drop-dosage form. At this hydrogen ion concentration the new hematinic agent, Zymatinic* Drops, supplies liver concentrate, folic acid, iron in the ferrous state and members of the B-vitamin complex in stable form for direct administration or mixed with acidulous fruit juices.

Zymatinic Drops meets every clinical requirement for furthering bone marrow activity and general metabolism in therapy of the anemias of infancy and childhood. The hematopoietic needs of children, multiplied by growth requirements, are more fully met with this well-tolerated and conveniently administered hematinic.

Guided by clinical requirements, Upjohn research workers have translated new knowledge of hematopoiesis into the practical form of Zymatinic Drops for use in the correction of the anemias of early years.

**Trademark*

Upjohn ***Medicine . . . Produced with care . . . Designed for health***

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN

2 new evaporated milk and Dextri-Maltose formulas for infants

Liquid Formulas

•

Convenient

•

Simple to Prepare

•

Nutritionally Sound

•

Generous in Protein

FOR ALMOST FOUR DECADES physicians have recognized the merits of infant-feeding formulas composed of cow's milk, water and Dextri-Maltose*.

In LACTUM and DALACTUM, Mead's brings new convenience to such formulas—for LACTUM and DALACTUM are prepared for use simply by adding water.

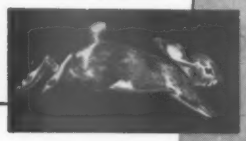
LACTUM, a whole milk formula, is designed for full term infants with normal nutritional needs. DALACTUM is a low fat formula for both premature and full term infants with poor fat tolerance. Both are generous in protein.

*T. M. Reg. U. S. Pat. Off.

MEAD'S

MEAD JOHNSON & CO.
EVANSVILLE 21, IND., U. S. A.

why let healing drag on and on and on . . .



in **BURNS**
slow healing **WOUNDS**
ULCERS
(decubitus, varicose, diabetic)

renew vitality of sluggish cells

stimulate healthy granulation

accelerate smooth epithelization[1]
with

Desitin®
OINTMENT

the external
cod liver oil
therapy

PROTECTIVE • SOOTHING • HEALING

℞ **Desitin Ointment is a stable blend of crude cod liver oil (with unsaturated fatty acids and vitamins A and D in proper ratio for maximum efficacy), zinc oxide, talcum, petrolatum, and lanolin. Minimizes scarring; dressings easily applied and painlessly removed. Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.**

Send for SAMPLES and new clinical reprint

Desitin CHEMICAL COMPANY
70 Ship Street, Providence, R. I.

1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Industrial Med. & Surg. 18:512, 1949.

Flavor appeals to Baby!

From the first spoonful of solid food, you can advise Beech-Nut for your young patients! No baby foods offer higher quality or finer flavor than a baby gets in Beech-Nut Cereal, Strained Foods and Junior Foods.

Babies love them—thrive on them

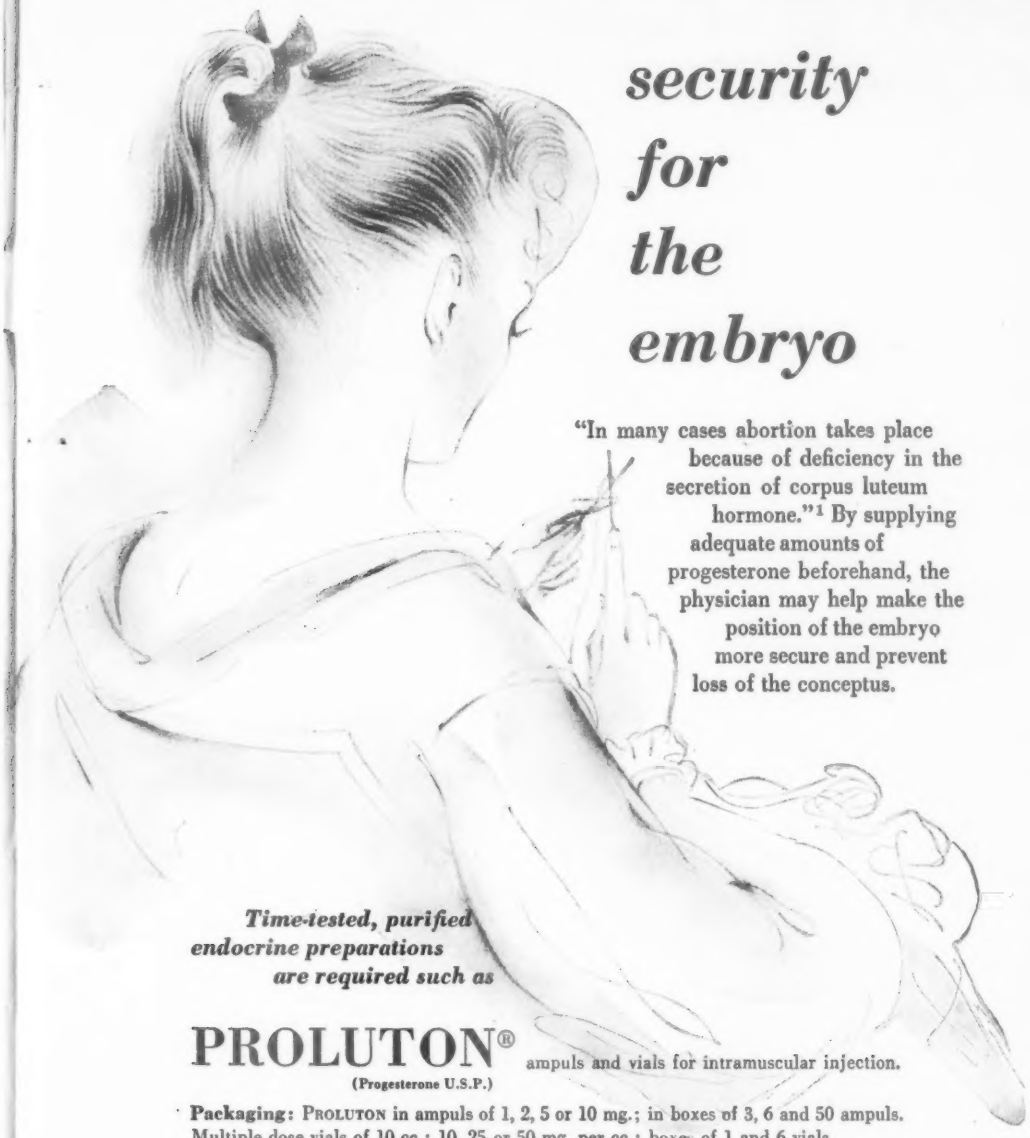
Beech-Nut

FOODS *for* BABIES

SOLD IN GLASS EVERYWHERE

Only one uniform method of packing

Beech-Nut high standards of production and ALL ADVERTISING have been accepted by the Council on Foods and Nutrition of the American Medical Association.



security for the embryo

"In many cases abortion takes place because of deficiency in the secretion of corpus luteum hormone."[1] By supplying adequate amounts of progesterone beforehand, the physician may help make the position of the embryo more secure and prevent loss of the conceptus.

Time-tested, purified endocrine preparations are required such as

PROLUTON®

(Progesterone U.S.P.) ampuls and vials for intramuscular injection.

Packaging: PROLUTON in ampuls of 1, 2, 5 or 10 mg.; in boxes of 3, 6 and 50 ampuls. Multiple dose vials of 10 cc.; 10, 25 or 50 mg. per cc.; boxes of 1 and 6 vials.

PROLUTON®

(Progesterone U.S.P. in POLYHYDROL*) Buccal Tablets—for intraoral administration.

Packaging: PROLUTON Buccal Tablets of 10 mg.; bottles of 30 and 100 tablets.

PRANONE®

(Anhydrohydroxy-progesterone U.S.P.) Tablets for ingestion.

Packaging: PRANONE Tablets of 5, 10 or 25 mg.; in boxes of 20, 40, 100 and 250 tablets.

1. Letters, Notes and Answers: Brit. M. J. *2*:68, 1945.
*T.M.

Schering CORPORATION
BLOOMFIELD, N. J.

PROLUTON

SCHERING

Rapid, sustained relief follows topical application of CALADRYL—the soothing new calamine-type antipruritic lotion containing BENADRYL®

CALADRYL

TRADE MARK

effective: CALADRYL effectively relieves sunburn and itching. Benadryl hydrochloride (1%), calamine, camphor, glycerin and other ingredients are blended in a soothing lotion for effective antihistaminic and antipruritic action.

pleasant: CALADRYL is pleasant to use. Faintly perfumed, its light flesh color is cosmetically inconspicuous. It does not rub off but washes off easily.

versatile: CALADRYL has many uses. It soothes sunburn's itching and burning. Prickly heat, diaper and cosmetic rash are readily relieved as is the itch associated with hives, insect bites, poison oak, poison ivy, measles, chicken pox, contact dermatitis, and minor skin affections.

PARKE, DAVIS & COMPANY

MEDICAMENTA VERA